

PRISONERS' EXPERIENCE OF HEALTHCARE IN ENGLAND:

Post-transfer to National Health Service responsibility A Case Study

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“It matters. We have a stake in it!”

(Comment professed at a male Prisoners’ Healthcare Forum by a prisoner member who is currently serving a life-sentence).

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For my children Daniel, Charlotte and Sophie
I love you beyond words.

And for Steve my wonderful, patient husband to whom I owe a huge debt of thanks. Without you this would not have been possible.

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Abstract

This thesis is concerned with the transfer of prison healthcare to National Health Service (NHS) responsibility, and investigates whether equitable provision has been achieved for prison-based patients.

The chronic ill health of prisoners in England has been recognised for centuries. For example, Howard debates the issue in 1784. When released from prison, English prisoners' abilities to carry ill health and infection into the community is more recently acknowledged as an additional significant concern (Ramsbotham, 1996).

Three themes are evident when analysing the policy and legislative background demanding fair and equitable provision for all. These are: Philanthropy and Concern for Prison Healthcare, Prison Specific Policy and Recommendations, and the Wider NHS Policy, National Service Frameworks and Strategies. Three distinct phases of the Public Health Agenda are considered in this thesis: 1784 - 1890, 1945 - 1996, and 1997 - 2010.

Investigation of the Public Health Agenda is divided into sub-categories: Health Promotion, Health Education, Disease Prevention, Healthy Settings, and Prisoner Health providing a valuable structure within which the wider literature can be evaluated empirically via this thesis' fieldwork.

Interpretivist in its methodology, this qualitative study adopts Case Study as an appropriate methodology. Research methods include focus groups, interviews, and participant correspondence. Presentation of research phenomena through graphic representation was designed to overcome reported literacy and language issues present within the research population. Combined, these methods offer an opportunity to build a "polyhedron of intelligibility" (Foucault, 1981, p. 6) demanded of this methodological approach.

Between 2005 and 2010, this study explored prisoners' experiences of healthcare post-transfer to NHS responsibility via five distinct phases of fieldwork: the identification of key patient themes of interest within a self-selecting sample, the validation of Phase One material and the generation of

additional themes, focus group discussions, followed by interviews with participants and wider stakeholders, and finally a discussion group.

Data are analysed and structured according to prison category and gender, age, and ethnicity. Resultant analytical themes linked to a central coding category, the overarching topic of *Patient Equivalence*. Furthermore, there are three analytical Key Themes: Beliefs, Attitudes and Behaviour; Service Commissioning, Delivery and Constraints; and Patients' Health and Patient Outcomes. Here, the identification of Imprisoned Carers provides a unique and novel finding of this work. From these three analytical categories, a Core Theory emerged.

Research data indicates that, despite considerable policy focus and activity, the lack of integrated service commissioning means that equitable provision for this prisoner population has not been consistently experienced by imprisoned patients. In its absence, prisoners have themselves adopted the role of carer for the sick and frail amongst their prison communities. These individuals report that they undertake these caring roles unsupported by the NHS and/or the Prison Service, whilst at considerable risk to both themselves and the person for whom they care.

To achieve equitable provision for English prisoners, this thesis suggests the development of a prison multi-agency health and social care integrated service commissioning plan which recognises the needs of imprisoned carers as highlighted in this study.

Contents	Page
Acknowledgements	3
Abstract	4
List of Figures	10
List of Tables	11
Abbreviations	13
Chapter One	Background and Theoretical Context 15
1.1 Introduction and Theoretical Context	15
1.2 Policy Implementation	20
1.3 Policy Themes	21
1.4 Health Policy Phase One	22
1.5 Health Policy Phase Two	27
1.5.1 <i>Interview Lord Ramsbotham</i>	31
1.6 Health Policy Phase Three	33
1.7 Prison Population in England	35
1.8 Prisoners' Rights to Equity	36
1.9 Healthcare Policy Sub-themes	39
1.9.1 <i>Equitable Healthcare</i>	40
1.9.2 <i>Integrated Care</i>	42
1.9.3 <i>Partnership</i>	43
1.9.4 <i>NSFs and National Priorities</i>	46
1.9.5 <i>Staff</i>	46
1.10 Conclusion	48
1.11 <i>Initial Research Questions</i>	51
Chapter Two	Literature Review 52
2.1 Introduction	52
2.2 Theoretical Framework	55
2.3 Literature Rationale	56
2.3.1 <i>Opportunistic Searching</i>	56
2.3.2 <i>Bibliographic Searching</i>	56
2.3.3 <i>Literature Review Summary</i>	58
2.3.4 <i>Accessing the Literature</i>	59
2.4 Public Health Agenda	59
2.5 Health Promotion	67
2.5.1 <i>Healthy Public Policy</i>	68
2.5.2 <i>Supportive Environments</i>	69
2.5.3 <i>Community Action for Health</i>	72
2.5.4 <i>Personal Skills</i>	74
2.5.5 <i>Re-orientation of Services</i>	76
2.6 Health Education	77
2.6.1 <i>Interventions, Programmes</i>	77

2.6.2	<i>Behavioural Change</i>	78
2.6.3	<i>Provision of Information</i>	80
2.6.4	<i>Skills and Self Esteem</i>	81
2.7	<i>Disease Prevention</i>	82
2.7.1	<i>Prevent Disease</i>	82
2.7.2	<i>Medical Intervention</i>	88
2.8	<i>Healthy Settings</i>	89
2.8.1	<i>Decisions, Life circumstances</i>	89
2.8.2	<i>Attainment of Health</i>	90
2.9	<i>Impact on Prisoner Health</i>	94
2.10	<i>Conclusion</i>	97
Chapter Three	Methodology and Methods	100
3.1	<i>Introduction</i>	100
3.2	<i>Ontology and Epistemology</i>	101
3.3	<i>Study Questions</i>	104
3.3.1	<i>Initial Research Questions</i>	104
3.3.2	<i>Overarching Study Questions</i>	104
3.4	<i>Study Design</i>	104
3.5	<i>Methodological Framework</i>	107
3.5.1	<i>Case Study</i>	109
3.5.2	<i>Theoretical Framework</i>	111
3.6	<i>Data Collection Theory...</i>	114
3.6.1	<i>Choice of Research Methods</i>	114
3.6.2	<i>Interviews</i>	115
3.6.3	<i>Focus Groups</i>	120
3.7	<i>Implemented Analysis Process</i>	127
3.8	<i>Interpretive Evidence Synthesis</i>	129
3.8.1	<i>Grounded Theory</i>	129
3.9	<i>Ethical Considerations</i>	133
3.10	<i>Methods</i>	135
3.10.1	<i>Background to Study</i>	135
3.10.2	<i>Initial Stage of Research</i>	135
3.10.3	<i>Research Timetable</i>	136
3.10.4	<i>Research Model</i>	137
3.11	<i>Phase One</i>	137
3.11.1	<i>Objective</i>	137
3.11.2	<i>Ethics Approval</i>	138
3.11.3	<i>National Permission</i>	138
3.11.4	<i>Qualitative Data Analysis</i>	138
3.11.5	<i>Phase One Prison Sample</i>	139
3.11.6	<i>Recruitment of Participants</i>	139
3.11.7	<i>Open Letter Phase One</i>	140
3.11.8	<i>Phase One Data Analysis</i>	141
3.12	<i>Phase Two</i>	142
3.12.1	<i>Phase Two Objectives</i>	142
3.12.2	<i>Validation Group Procedure</i>	142
3.12.3	<i>Governor's Permission</i>	143
3.13	<i>Phase Three</i>	145
3.13.1	<i>Phase Three Objectives</i>	145
3.13.2	<i>Male Focus Group</i>	147
3.13.3	<i>Women's Focus Group</i>	148

3.14	Phase Four	149
3.14.1	<i>Phase Four Objective</i>	149
3.14.2	<i>Interview Procedure</i>	149
3.14.3	<i>Interview Young Person</i>	149
3.14.4	<i>Open Interviews</i>	149
3.14.5	<i>Lord Ramsbotham</i>	151
3.14.6	<i>Head of Healthcare</i>	151
3.14.7	<i>Acting Head of Healthcare</i>	151
3.14.8	<i>Interview Imprisoned Carer</i>	152
3.15	Phase Five	153
3.15.1	<i>Phase Five Objective</i>	153
3.15.2	<i>Discussion Group</i>	153
3.15.3	<i>Multi-Professional Stakeholders</i>	153
3.16	Validity	154
3.17	Sample Size Justification	154
3.18	Conclusion	155
		155
Chapter Four	Data Analysis	156
4.1	Introduction	156
4.2	The Case	157
4.3	Implications of Researcher Bias	159
4.4	Data	162
4.4.1	<i>Prison Categories</i>	164
4.4.2	<i>Participant Gender</i>	166
4.4.3	<i>Participant Ethnic Status</i>	166
4.4.4	<i>Participant Age Profile</i>	167
4.5	Conceptual Analysis	168
4.5.1	<i>Colazzi's Framework</i>	168
4.6	Themes	172
4.7	Data Software Management	176
4.8	Data Analysis Procedure	179
4.9	Category Saturation	180
4.9.1	<i>Open Coding</i>	180
4.9.2	<i>Theoretical Saturation</i>	181
4.10	Key Themes	181
4.11	Building a Grounded Theory	182
4.12	Developing Themes into Theory	189
4.13	Core Theory	190
4.14	Conclusion	202
Chapter Five	Presentation and Analysis of the Fieldwork Findings	203
5.1	Introduction	203
5.1.1	<i>Access to Specialists</i>	204
5.1.2	<i>Alcohol Abuse</i>	211
5.1.3	<i>Assessment</i>	212
5.1.4	<i>Carers</i>	213
5.1.5	<i>Complaints</i>	216

5.1.6	<i>Disability Issues</i>	225
5.1.7	<i>Dispensary Opening Times</i>	226
5.1.8	<i>Drug Misuse</i>	228
5.1.9	<i>External Support</i>	235
5.1.10	<i>Healthcare facilities</i>	239
5.1.11	<i>Healthcare Staff</i>	245
5.1.12	<i>Medical Records</i>	252
5.1.13	<i>Medication</i>	254
5.1.14	<i>Mental Health Issues</i>	260
5.1.15	<i>Prison Environment</i>	261
5.1.16	<i>Prison Hygiene</i>	263
5.1.17	<i>Prison Regulations</i>	263
5.1.18	<i>Prison Staff</i>	264
5.1.19	<i>Prison Sub-cultures</i>	266
5.1.20	<i>Privacy</i>	267
5.1.21	<i>Social Care</i>	268
5.1.22	<i>Treatment</i>	269
5.1.23	<i>Variation in Healthcare</i>	271
5.1.24	<i>Waiting Times</i>	272
5.2	<i>Conclusion</i>	273
Chapter Six	Discussion of Findings	276
6.1	<i>Introduction</i>	276
6.2	<i>Patients' Behaviours, Health...</i>	280
6.3	<i>Healthcare Setting...</i>	288
6.4	<i>Service Commissioning, Delivery...</i>	295
6.5	<i>The Case</i>	298
6.5.1	<i>Why did it Happen?</i>	300
6.5.2	<i>How did it Happen?</i>	300
6.5.3	<i>What was Connected to What?</i>	302
6.5.4	<i>What was the Impact on Patients?</i>	303
6.5.5	<i>Factor inter relationship</i>	307
6.6	<i>Implications for Policy and Practice</i>	309
6.7	<i>Concluding Remarks</i>	310
6.8	<i>A Final Thank You</i>	312
6.9	<i>Limitations</i>	313
6.9.1	<i>Study Method</i>	313
6.9.2	<i>Study Content</i>	316
6.9.3	<i>Thesis Postscript</i>	318
6.10	<i>Study Development</i>	320
References		323

List of Figures

Figure 1	Theoretical Framework	19
Figure 2	Theoretical Framework Micro Level	21
Figure 3	Theoretical Framework Public Health	56
Figure 4	Graphic Board	144
Figure 5	Carers' Graphic Icon	145
Figure 6	Assessment Graphic Icon	148
Figure 7	Young Persons' Graphic Icon	151
Figure 8	Social Care/Staff Conflict Graphic Icons	152
Figure 9	The Case	158
Figure 10	Prison Categories	164
Figure 11	Prisoner Gender Categories	166
Figure 12	Participant Ethnicity	167
Figure 13	Participant Age	168
Figure 14	Initial Research Themes	171
Figure 15	Grounded Theory Step 1	183
Figure 16	Grounded Theory Step 2	184
Figure 17	Data Analysis and Theory Generation	186
Figure 18	Coding Process	187
Figure 19	Grounded Theory Step 3	188
Figure 20	Core Theory Model	190
Figure 21	Generation Core Theory Prisoners' Re(constructed)	278
Figure 22	Healthcare Experience	280

List of Tables

Table 1	Time Line Phase One 1784-1890	23
	Time Line Phase Two 1945-1996	27
Table 2		
Table 3	Time Line Phase Three 1997-2010	33
Table 4	Wider NHS Policy Sub-themes	39
Table 5	Literature Review Search Terms	57
Table 6	Thomas's Model	112
Table 7	Research Timetable	136
Table 8	Phase One Graphic Icons	142
Table 9	Womens' Focus Group Graphic Icons	149
Table 10	Prison Category Clusters	162
Table 11	Total Participant Table	165
Table 12	Initial 14 Themes	172
Table 13	Context Clusters	174
Table 14	Participant Cohort Research Themes	180
Table 15	Key Themes	189
Table 16	Access to Specialists	191
Table 17	Alcohol Abuse	191
Table 18	Assessment	192
Table 19	Carers in Prison	192
Table 20	Complaints	192
Table 21	Disability Issues	193
Table 22	Drug Misuse	193
Table 23	External Support	194
Table 24	Healthcare Facilities	194

Table 25	Healthcare Staff	195
Table 26	Medical Records	196
Table 27	Medication	196
Table 28	Mental Health Issues	197
Table 29	Prison Environment	197
Table 30	Prison Hygiene	197
Table 31	Prison Regulations	198
Table 32	Prison Staff	198
Table 33	Prison Sub-cultures	199
Table 34	Privacy	199
Table 35	Social Care	199
Table 36	Treatment	200
Table 37	Variation in Provision	201
Table 38	Waiting Times	201
Table 39	Themes Complete List	203
Table 40	Case Study Questions	298

Abbreviations

ABCD	Prison Categories
AIDs	Acquired Immune Deficiency Syndrome
BME/BMaE	Black and Minority Ethnic
CARAT/S	Counselling, Assessment, Referral, Advice and Throughcare Scheme
CAT	Category (Prison)
CJS	Criminal Justice System
CL	Closed
CPN	Community Psychiatric Nurse
CQC	Care Quality Commission
DoH/DH	Department of Health
DIP	Drug Intervention Programme
EU	European Union
F	Females
GMC	General Medical Council
GP/s	General Practitioner/s
HcC	Healthcare Commission
HImPs	Health Improvement Plans
HIV	Human Immunodeficiency Virus
HM	Her Majesty
HMCIP	Her Majesty's Chief Inspector of Prisons
HMIP	Her Majesty's Inspectorate of Prisons
HMPS	Her Majesty's Prison Service
HNAs	Health Needs Assessments
ICAS	Independent Complaints Advocacy Service
IDTS	Integrated Drug Treatment System
IMB	Independent Monitoring Boards
IMR	Instant Medical Report form
ICT	Information and Communications Technology
IT	Information Technology
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LGBT	Lesbian, Gay, Bisexual and Transgender
M	Males

MDA	Methadone Dispensing Prescription
MDT	Mandatory Drug Testing
MoJ	Ministry of Justice
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant Staphylococcus Aureus
NACRO	National Association for the Care and Resettlement of Offenders
NHS	National Health Service
NSF/s	National Service Framework/s
NUD*IST	Non-numerical Unstructured Data Indexing Searching Theorising
O	Open
PALS	Patient Advice and Liaison Service
PCG/s	Primary Care Group/s
PCT/s	Primary Care Trust/s
PSI	Prison Service Instruction
PSO	Prison Service Order
RC	Remand Centre
RES	Resettlement
RGN	Registered General Nurse
RMN	Registered Mental Health Nurse
StHA	Strategic Health Authority
S-O	Semi-Open
STC	Secure Training Centre
STD	Sexually Transmitted Disease
STI/s	Sexually Transmitted Infection/s
UK	United Kingdom
UNLOC	University of Nottingham On-line Catalogue
WHO	World Health Organisation
YOI	Youth Offender Institute
YOS	Youth Offending Service

CHAPTER ONE: BACKGROUND AND THEORETICAL CONTEXT

Many of the bridewells are crowded and offensive because the rooms which were designed for prisoners are occupied by lunatics... no care is taken of them, although it is probable that by medicines, and proper regime, some of them might be restored to their senses and usefulness in life

Howard (1784, p. 8).

1.1 Introduction and Theoretical Context

This chapter provides the theoretical context within which this thesis is located. It also presents critically the policy and legislation literature relevant to the pursuit of equitable healthcare for prisoners in England. This research investigates whether prisoners can achieve an equivalent status with National Health Service (NHS) patients in the community, yet within this complex penal environment.

The notion of health policy is reviewed first.

It is worth briefly explaining this research aim at the outset, as an understanding of this study's objective helps frame the literature review and research design chapters of the thesis for the reader. Therefore, as Chapter Two demonstrates, insufficient literature currently exists that addresses the presence/absence of equitable healthcare for Her Majesty's Prison Service (HMPS) patients. This work addresses this important gap. Moreover, due to this lack of contemporary attention in the research, development, and policy fields, the data from this research and their analyses represent original research findings, implications, and conclusions.

In terms of notion of health policy, it is argued that, at a theoretical level, its development is driven by three key factors (Ham, 2004). The first is an increased recognition of the pertinent health-related issues. For this thesis, the

ill health prevalent amongst the prison population is of primary importance. This issue has been widely discussed via a number of texts (e.g. Bradley, 2009; Braveman and Gruskin, 2003; Condon *et al.*, 2008; Fazel *et al.*, 2005; Hayward *et al.*, 2008; HM Chief Inspectorate of Prisons Youth Justice Board, 2009; Moran and Peterman, 1989; Stewart, 2007). Despite numerous challenges identified in this body of literature, incarceration is argued to provide a unique opportunity to achieve real health improvement for all imprisoned patient groups (Department of Health, 2002a; Department of Health, 2004). Yet, a fundamental conflict between policy intent and prisoners' ability to benefit from it is evident and, for some academics in the field, the very concept of a healthy prison is an "oxymoron" (de Viggiani, 2007, p. 115).

Secondly, health policy development is considered to be a dynamic process affected by groups and individuals who have the power to influence (Ham, 2004). Within this theoretical framework, Pluralist theorists argue that the ability to sway policy does not rest with any single dominant group (Dahl, 1961). Conversely, the emergence of corporatism would assert that powerful interest groups have the ability to become part of the governmental system itself. This inclusion, it is argued, could ultimately avoid conflict (Middlemass, 1979). Notably, those with close strategic alliance are considered to be particularly well placed to effect change (Cawson, 1982).

A critical examination of the health policy literature indicates that imprisoned patients' journey towards equity, in relation to healthcare provision and access to healthcare services, has been a long one. The historical context from which the theoretical promise of equitable healthcare emerged is, therefore, also a matter for consideration. Additionally, the policy drivers which led to Primary Care Trusts (PCTs) in England, assuming responsibility for the commissioning of healthcare in prisons by 2006, must also be placed within a wider legislative context. Indeed, this thesis asserts that this is increasingly influential on policy development at a national level. Several issues relevant to this historical development are now overviewed.

Firstly, the principle of equivalence and its introduction are important. The ethical principle of justice, especially for the vulnerable, in terms of access to resources is acknowledged within the document *The Future Organisation of*

Prison Healthcare (Joint Prison Service and National Health Service Executive Working Group, 1999). Clinically formulated as the *principle of equivalence*, this key report stated that prisoners should be entitled to “the same quality and range of health care services as the general public receives from the National Health Service” (Joint Prison Service and National Health Service Executive Working Group, 1999, p. 5). Moreover, stakeholders responsible for bringing about this transfer were tasked to deliver these services within an extensive framework of legislation, instruction, regulation, and practice (see Appendix A).

It could be inferred that the legislative and policy framework highlighted here presented a noteworthy challenge for those charged with the implementation of this national programme of change. Further, equity is an elusive term. Indeed, no single definition exists. As such, it is not something that can be easily measured, and has become a convoluted construct. This thesis acknowledges aptly the complexity of the notion of equivalence in relation to healthcare. The principle of justice is central to the understanding of equivalence at the level of the individual patient, free from bias and discrimination. This thesis is implicitly based on the assumption that equitable healthcare can be achieved for this prisoner patient grouping.

Here, it is further offered that prisoners represent a unique NHS patient population. The construct of equity formulated here stands in direct conflict with the inequality created when an individual’s liberty is constrained through the, albeit legitimate, act of incarceration. If prison health policy is to be successful in practice in the penal setting, access to equitable provision, without discrimination, must be clearly visible when it is applied for this patient group.

Further, the appearance of prisoners as NHS patients and full members of society, entitled to universal respect for their rights, including health-related, should also be clearly apparent in the penal setting for all involved. To exemplify the prison setting, wider government policy withholding prisoners’ rights to vote alongside pension contributions, indicate that prison health policy may align poorly within the wider, and somewhat intolerant, prison policy landscape.

This fundamental underlying tension between legislation, policy and practice is exemplified by the ruling of the Court of Human Rights, *Hirst vs the United Kingdom (No2)*, 2005. This challenged the total ban on prisoners' voting rights. Here too, this practice has a long history and dates back to 1870 in England. The Court found in favour of Hirst, ruling that this exercise contravened Protocol 1, Article 3 of the European Convention on Human Rights.

Despite the clarity of this ruling, successive British governments' have refused to comply. When finally faced with the threat of a £160m financial penalty, the Prime Minister David Cameron commented during a Parliamentary debate:

[...] it makes me physically ill to contemplate giving the vote to prisoners... They should lose some rights including the right to vote (House of Commons, November 3rd, 2010).

Equitable prisoner healthcare policy has the potential to be compromised, therefore, by political antipathy at a broader level. In the face of this and other challenges, it seems that that, within the complex penal environment, the experience of healthcare equity, as experienced by prisoners, remains deeply personal and subjective, yet largely uninvestigated. As such, it cannot easily be estimated or evaluated by any external parties. Here, health equity will ultimately be explored and analysed through the perceptions of imprisoned patients themselves, those who have experienced prison healthcare post-transfer to NHS responsibility. This will be demonstrated through the analytic framework applied to this work.

Critical analysis of the World Health Organisation's (WHO) reports and documents presents a working definition of equity which is more broadly applied. This, and the issue of fairness, provides a valuable reference point for this work. Here, inequity in health is considered both unfair and unjust when the situation is "unnecessary and avoidable" and the individual or community is powerless to exercise "choice" in such matters (Whitehead, 2000, p. 7).

This issue of choice offered here, leads this chapter into the third and final element of the health policy theoretical framework presented, namely a consideration of those with the power to choose or determine who benefits from health policy. Arising from this, effective lobbying coupled with an improved understanding of the underlying causes of disease emerge as key influences on successive Governments' philosophical views regarding the importance of Public Health in England.

Fundamentally for prisoners, the varied political salience and development of this Public Health Agenda (the Governments' policy vehicles to deliver improved Public Health) has emerged within three distinct timeframes: 1784-1890, 1945-1996 and 1997-2010. Policy makers' opinions are clearly seen within the healthcare policy literature to be at times affected by philanthropic endeavour to improve the lives of the sick (Howard, 1784). This has led to the movement of financial and medical resources around the healthcare system, directly affecting prisoners' abilities to achieve equity regarding NHS healthcare.

The following framework graphically depicts the three elements of successful health policy implementation considered essential by Ham (2004).

Figure 1
Theoretical Framework



Figure 1 illustrating the key elements of health policy development in England.

At a macro theoretical level, this thesis argues that health policy development looks less like an evolutionary process. It emerges instead from tectonic political pressure applied by the persuasive arguments brought to bear on those in power, and is, therefore, unpredictable. As a result, the development of healthcare policy at a theoretical level is confusing, contradictory and at the mercy of those exerting the greatest political force. Cunningham

commented: “policy is rather like the elephant – you recognise it when you see it but cannot easily define it” (as cited in Smith, 1976, p.12).

1.2 Policy Implementation

The machinations of abstract theoretical health policy debate are unlikely to be of interest to many prisoners. Of more relevance is the direct translation of policy into service provision, or lack of it. If this is indeed the case, it is important to reflect on a number of factors which are considered essential to the successful execution of healthcare policy in practice. These implementation processes are now discussed in a chronological sense, beginning in the 1960s.

As early as 1953, Easton argued that an understanding of how policy is implemented is of equal importance to an awareness of how it is made. Easton (1953) further posited that the development of health policy encompasses both formal, and informal, decisions and actions. In this way, policy is seen to develop via clinicians’ selections from a range of choices. The resultant action, therefore, may not be what was originally intended by policy makers, thus supporting the aforementioned tectonic policy influence metaphor offered here. Moreover, informal, or hidden, pressure may be particularly effective, yet often unseen and un-researched.

Consequently, if health policy is to be increasingly successful policy must survive. Solesbury (1976) argued that, in order to do so, issues must be capable of passing three tests, namely: become legitimate, command attention and invoke action. Without this, new policies, Ham (2004) later asserted, run the risk of suppression or tokenism.

Figure 2

Theoretical Framework at a Micro Level

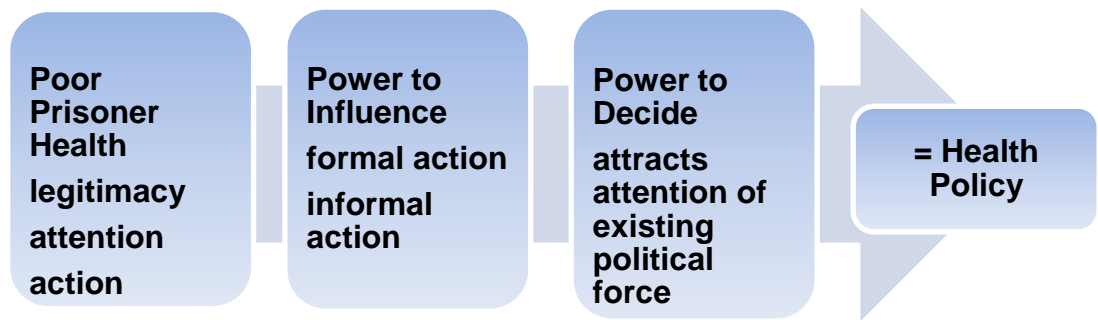


Figure 2 illustrating the key elements of health policy implementation in England.

1.3 Policy Themes

The policy literature pertinent to prisoners is extensive and gives rise to three Key Themes. They promise opportunities to improve health and wellbeing. These themes are:

1. Philanthropy and Concern for Prison Healthcare,
2. Prison Specific Policy and Recommendations,
3. Wider NHS Policy, NSFs and Strategies.

An impressive body of academic texts have suggested over a number of years why equity in health is important. Of these, a number of reviews have been particularly influential (Fox, 1984; Gunning-Schepers, 1989; Kohler and Martin, 1985; Illsley and Svensson, 1986; Townsend and Davidson, 1982; Whitehead, 1988). Consistently, it is asserted that disadvantaged groups and individuals have poorer survival chances. Further, the literature would suggest that, during their lifetimes, these individuals will spend a greater proportion of their time affected by long-term illness and disability (Phillimore, 1989). On humanitarian grounds, therefore, inequity in health, if it is to be addressed, demands a response which is both strategic and pragmatic.

If one were to accept the theoretical basis for Solebury's (1976) and Ham's (2004) arguments, health improvement will not be attained without the

strategic alignment of healthcare policy and practice, with clinical practice and the setting for policy enactment. Currently in England, the Public Health Agenda, supported by key drivers such as the National Service Frameworks (NSFs), functions as the central framework to deliver improved health for the whole UK population.

It is important to reflect with hindsight, however, that healthcare policy has been developed, often incrementally, over 400 years. Notably, each period has built on the last; the health policy landscape in the UK has extensive historical roots. However, an analysis of health policy demonstrates that policy ambition does not always create its desired change and consequences, supporting Easton's aforementioned argument (1953).

Further, the recognition that we live in an "unequal society", and the extent to which the "state should attempt to alleviate inequalities in health" (Taylor and Hawley, 2010, p. 85) features as an underlying tension in this thesis. The multifarious ways in which health policy is challenged by, and must respond to, societal and health inequalities and wider political opinion is another aspect of the health equity debate presented here.

The initial cluster of activity and its subsequent impact on prisoner health will be considered in the section to follow, alongside the historical evolution of this area of healthcare policy.

1.4 Health Policy Phase One

Concern for the welfare of prisoners, particularly those with mental health conditions (All-Party Parliamentary Group on Prison Health, 2005), is not novel for the UK's Prison Service and its (now NHS), healthcare services. For example, philanthropic political influence pertinent to the theoretical model offered here was prevalent in the 18th and 19th centuries in England. This time period also witnessed the establishment and implementation of the first phase of English Public Health Policy intended to improve the health of all citizens. Together with the development of prison-specific health services, these activities critically focused political attention on prisoner health for the first time.

Table 1**Time Line Phase One 1784–1890**

The table below shows the first phase of the health policy timeline.

Philanthropy and Concern for Prisoner Welfare	Prison Specific Policy and Recommendations	Wider NHS Policy, NSFs and Strategies
1784 John Howard Prison Campaigner – concern for mentally ill and poor living conditions		
	1784 Requirement for prisons to appoint a surgeon or apothecary	1830 Appointment of the first Medical Officer for Health in England
	1791 Philosopher Jeremy Bentham designs Panopticon (ideal prison) and formulates the concept of <i>less eligibility</i>	
Public Health Phase One Responsibility placed on Society	Public Health Phase One Responsibility placed on Society	Public Health Phase One Responsibility placed on Society
1817 Elizabeth Fry campaigns for prison reform		
	1835 Prison Inspectors introduced	
		1846 Liverpool Act
1855 Concern for the <i>deserving poor</i> and development of asylums in England		1846 - 71 Small Pox Vaccination
		1848 - 75 National Public Health Acts in England
		1870 Declining role of the Poor Law
	1877 Establishment of Prison Medical Service	
	1878 Prisons Act	
1880 onwards general improvement in Public Health		
		1890 Establishment of Great Ormond Street Hospital
	1900 Prison population in England and Wales 17,435	

An early example of powerful influence on prison health policy and the government of the day was the work of the pioneering prison reformer John Howard. Appointed the High Sheriff of Bedford, Howard became responsible for the county gaol. Appalled by the dreadful conditions he discovered, he travelled widely in search for more humane prison regimes, only to find that the malpractice in Bedford was common across England and Wales. His work led, in 1784, to the requirement for all prisons to appoint a surgeon or

apothecary. As a result, prisons today claim the oldest civilian medical service.

Howard's argument that prisons should be healthy and disease-free was published in his work *The State of the Prisons in England and Wales* (1784). It proved influential, and established this as a legitimate issue with the Government. Its importance for English prisoners cannot be underestimated. It is likely that his effective lobby brought him into direct conflict with wider political arguments at that time, in particular, Jeremy Bentham's principle of *less eligibility* (Bowring, 1843), later developed by the Twentieth Century critical theorist and criminologist George Rusche.

Whether it matters that one section of society has a worse health experience than others has long been debated (Taylor and Hawley, 2010). Inequity in health experienced by citizens is acknowledged to reflect the wider social ills prevalent in societies (Whitehead, 2000). The central feature of Taylor and Hawley's (2010, p. 87) argument is "whether the state has an obligation to tackle inequalities in general and health inequalities in particular" when one considers that inequity is "positively encouraged in a capitalist economy". Broadly speaking, the literature on this issue falls into two political perspectives. Firstly, the social democrat position which is committed to the reduction of inequity of all kinds where found to exist and, secondly, the neo-liberal position which posits a non-interventionist approach at the level of the state.

It could be suggested that the investment in prison physicians provides an early example of a policy of positive discrimination aimed at improving the health of a specific patient group. Further, this intervention appears to reflect a social democratic perspective highlighting early state involvement in this agenda, and a clear attempt to reduce health inequity for this disadvantaged prisoner population.

By necessity, this would involve giving a disproportionately large share of society's resources to one particular group. This way, academics have argued, individual's wider chance in life would be improved (Hoedemaekers and Dekkers, 2003). However, the attendant resource inequity discussed has

been found by others to engender feelings of hostility amongst the wider population (Colledge, 1986). Indeed, at that time, early perception that prison conditions had improved attracted some level of public reproach when Charles Dickens, for instance, wrote:

We have come to this absurd, this dangerous, this monstrous pass, that the dishonest felon is, in respect of cleanliness, order, diet, and accommodation, better provided for, and taken care of, than the honest pauper (as cited in Oulton, 2003, p. 23).

Those striving for health improvement are found, therefore, to walk a delicate and difficult policy path in which wider public opinion is an ever present political force.

Howard was one amongst a number of widely recognised prison reformers of his day. Amongst his peers, the work of Fry and Bentham is particularly well known. Their work is not, however, without controversy. Cooper (1981) would later argue that the Quaker movement rejected many of Fry's opinions, and the influence of Bentham was negligible. The work of Howard has remained less contentious. This is particularly significant as it led to what Ham (2004) described as a clear and meaningful call to action. This resulted in an undisputed transformation in prison health policy which would later radically change prison health provision in England, discussed later in this chapter.

Chronic sickness and poor living conditions, at that time, were not restricted solely to the prison population. Philanthropic activity to raise awareness of the ill effects of poverty and disease resulted, in England, in the development of healthcare policy at societal level and the appointment of Dr Duncan, the first Medical Officer of Health. This action heralded the first phase of the Public Health movement (Ashton and Seymour, 1988) at a time when wider determinants of health, such as poor housing, poverty, and working conditions, created disease that had no respect for social boundaries. As a result of these conditions, the rich were dying alongside the poor (Watts, 1997). Shared Public Health issues were also problematic. It is suggested here that, although individuals commanded widely different levels of resource, their health experience was equitable, as it was equally poor.

Prior to the development of advanced medical practice, the Government's health policy response at that time was to establish a clear strategic framework for health improvement, and divert resource into key initiatives. Early substantiation of this can be seen in the health policy literature in the publication of the *Liverpool Act* (known as the Liverpool Sanitation Act) and *National Public Health Act* in England between 1846 and 1875 (Ashton and Seymour, 1988). Coupled with improved work and living conditions, communities were empowered, for the first time, to affect their own health. The development of the Small Pox vaccine in 1848, asylums, early hospitals, and other facilities for the sick and poor, further improved the underlying health of the population. These successes, it has been said, were directly attributable to the societally focused Public Health Policy adopted (McKeown, 1976). Moreover, they also provide the earliest clear examples of improved patient outcomes, long before this terminology appeared in the English medical language.

The policy literature also shows that much of the early success of Public Health intervention was surprisingly sophisticated for its age. Indeed, the understanding of the wider determinants of disease in poor communities would be recognisable in Public Health Policy today. Further, this would indicate that health inequality during this period functioned within a broader social policy framework. This suggests that individuals were not viewed by policy makers as being solely responsible for their own ill health. These views would later be challenged, and will be returned to in Phases Two and Three of the critical policy timeline to follow.

Beside the healthcare policy and legislative response of the day, medicine began to emerge as a professional scientific discipline. This body would later acquire the power and influence to secure Public Health resources for medical intervention. Within this cohort, doctors began to influence health policy at both a micro and macro level, arising from society's "wish" to believe in their "extreme skill" (Harrison *et al.*, 1992, p.18). It could be argued that these were the early examples of patient disempowerment at both a national and local level, and the rise of doctors as a powerful interest group within the Corporatist element of the theoretical framework presented.

Moreover, this movement in healthcare resource unintentionally weakened Public Health Policy in the community. It disempowered the vulnerable, in particular, by reducing health-related choices under their control adding further support to Easton's (1953) unintended consequences theory. This will provide a focus for the section to follow.

1.5 Health Policy Phase Two

Table 2

Time Line Phase Two 1945-1996

The table below shows the second phase of the health policy timeline.

Philanthropy and Concern for Prisoner Welfare	Prison Specific Policy and Recommendations	Wider NHS Policy, NSFs and Strategies
Public Health Phase Two Responsibility transferred to Doctors	Public Health Phase Two Responsibility transferred to Doctors	Public Health Phase Two Responsibility transferred to Doctors
1945 Birth of the Welfare State		
		1948 Establishment of the NHS
		1950 <i>Convention for the protection of Human Rights & Fundamental Freedoms</i>
		1981 <i>World Health Organisation Global Strategy for Health for All</i>
1990 <i>Community Care Act</i>	1990 Prison Medical Service Purchaser/Provider split	
1996 Ramsbotham HMCIP <i>Patient or Prisoner?</i>		

This section develops from the health and social policy framework outlined in the previous section, and charts the rise of healthcare and wider Government policy. The commencement of this period could be considered from multiple ideological perspectives. This phase of the policy timeline witnessed a profound transition in the political climate in England. As a result, healthcare and health policy was seen to vacillate under the influence of the political dogma of successive governments.

Here, a critical appraisal of the healthcare policy literature highlights a clear division in this underlying political ideology. Whether individual patients were entirely responsible for their own health experience, and had any right to

expect State assistance is central to this debate. Arising from this, the State's willingness, or unwillingness, to challenge health inequity profoundly impacted the lives of the sick. An acknowledgement of the underlying political bias inherent in the healthcare policy literature is, therefore, an important factor to be considered when this material is discussed.

The 1950s saw the emergence of the powerful new ideology and vision for social democracy determined by collective political action, previously introduced in Phase One. Of particular relevance to this thesis, at this time English citizens were offered welfare and assistance. Crucially, the right to equitable healthcare appears in legislation for this first time and, upon this platform, prison health reform would later stand.

Post-war England also witnessed the birth of two systems designed to improve the lives of its population, the Welfare State and the National Health Service. These key developments promised resources, and in the case of the NHS, access to healthcare services which were free to all at the point of delivery. At the same time, the continued rise of the medical profession in England and scientific improvement in the care of patients, regardless of competing theoretical and political ideology, were welcome. For the newly established NHS, however, this period would witness the majority of healthcare resource transferring from community healthcare services to the acute hospital sector (Allen and Hicks, 1999).

The emergence of neo-liberalism in post-war England was critical of State intervention in health (Hayek, 1960). Moreover, it was argued that State intervention was a "coercive" form of control which failed to recognise the importance of the personal bond between patients and their clinicians (Taylor and Hawley, 2010, p. 28). Driven by a profound belief that the natural position for citizens was to compete rather than co-operate, neo-liberalists argued in favour of health privatisation and increased patient choice within a low-tax environment (Taylor and Hawley, 2010). These views would re-emerge later with successive changes in government, and will strongly influence patient experience in England.

Despite the promise of improved health and healthcare, and strong political energy and focus, examples of inequitable provision in the wider community can be found in the literature about this period (Bridgwood and Malbon, 1995; Smith, 2000). Here, despite the promise of healthcare for all, a two-tier service emerged, widening still further the gap between rich and poor (Whitehead, 1988). Poverty, frailty, and other factors created invisible barriers through which the vulnerable had to pass in order to access the services they needed (Stiehm, 2001). Of concern, the wealthy, educated, and mobile faced fewer difficulties, thus accelerating the inequity in the health experience and access for many (Townsend *et al.*, 1988).

Support cannot be found in the health policy literature which suggests the disadvantage for some was intentional. Instead, the discovery of expensive new treatments with the promise to cure or prolong life, presented a compelling case for ever-increasing levels of resource. Similarly, in conflict with the Marxist health policy theory, examples of a deliberate intention to exclude the most vulnerable members of society from the benefits of medical advances, recognised and described as the Inverse Care Law (Tudor Hart, 1971), do not exist. Indeed, successive Governments, with limited achievement, have strived to reverse this inequality ever since (Department of Health, 2004).

Blaxter (1984), and Cartwright and O'Brien (1976) found, for example, that the socially disadvantaged experienced shorter consultations with their physicians, and were referred less often to specialist healthcare services. Moreover, it is posited here that society's ability to both affect, and effect its own health was negatively constrained. This second phase of Public Health Policy signalled a complete reversal of the societal focus for Public Health presented in its first iteration.

Here, the inequity in healthcare provision was subtle. Moreover, academics have argued that it may not even have been inflicted at a conscious level (Blaxter, 1984; Cartwright and O'Brien, 1976). Its eradication, therefore, presents a challenge to those attempting to achieve equitable health status, not just for prisoners, but for the wider community also.

As a further complication, the policy literature is abundant with detrimental and unintended consequences which again support Easton's (1953) earlier argument. It is somewhat ironic that Howard's effective lobby in 1784 discussed previously presents one such example. This had resulted in clear Government action to establish the Prison Medical Service. Consequently, as an exemplar of best practice of the day, its very existence contributed to prison healthcare being omitted from the NHS at its establishment in 1948, and led to increasingly poor provision for the imprisoned.

Although the laudable intention behind this strategy is not criticised in the health policy literature, a powerful body of opinion would later argue that the prison service was failing to provide an equivalent standard of care to that of the NHS (Health Advisory Committee for the Prison Service, 1997; Plant *et al.*, 2002; Reed and Lyne, 1997; Sim, 1990). A Governmental response was clearly required and, in an attempt to address this criticism, the Home Office (1990) recommended that the then Prison Medical Service be re-organised along purchaser/provider lines. This was later found, however, to have been of limited success (The Joint Prison Service and National Health Service Executive Working Group, 1999). No clear strategic direction can be identified in the literature at this time, and numerous developments in healthcare policy were trialled throughout this period with varying levels of success.

One such attempt has been included here as an exemplar of a plethora of similar, and generally unsuccessful, health policy initiatives. Here, citing examples in the reports of the HM Chief Inspector of Prisons (Joint Prison and National Health Service Executive Working Group, 1999, p. 3). The Executive Working Group, for example, argued that the role of the service should be widened to emphasise more strongly the promotion of health (Home Office, 1990). More significantly for prisoner health improvement, the Home Office (1990), whilst recommending the split, promoted the benefit of a Public Health approach in prison. Appearing for the first time in the policy literature, this recognition suggests an underlying Government Agency's increasing acceptance of the potential value of this approach for prisoners. A wider public concern for these issues was absent. If this indicates prejudice, a simple lack of awareness, or a combination of both, cannot be established.

Despite this and numerous similar attempts, at a theoretical level, the growing legitimacy of these issues in the policy literature suggests the emergence of a new wave of effective political persuasion. Her Majesty's Chief Inspector for Prisons (HMCIP) Sir (now Lord) David Ramsbotham's call for the transfer of prison healthcare to NHS responsibility is visible in the literature at this time.

Drawing attention to the overwhelming, but hidden, levels of sickness and chronic illness behind the prison walls HMCIP posed the question *Patient or Prisoner?* (1996). This paper questioned the poor healthcare provision that the author had witnessed for imprisoned patients, and in particular for those with mental health issues.

Here it is posited that this paper also re-established the link between prisoner health and the community. Citizens were explicitly told that prisoners would return, carrying with them ill health and disease unless this had been effectively treated during their incarceration. Legitimacy was, therefore, claimed in the eyes of the Government and wider population, thus providing an excellent illustration of and meaningful and effective call to action at both a practical and theoretical level.

It was essential for this thesis to ascertain what had led to this central publication, and an open interview was requested to elicit this information.

1.5.1 Interview with Lord David Ramsbotham

The interview took place in December 2006. The interviewee recounted that, until 1993, he had been a professional soldier. Having previously chaired an NHS Hospital Trust and been a hospital lay assessor for some time, he was invited to become HMCIP in 1995. During this period, he became particularly concerned about the number of imprisoned young people with advanced schizophrenia, many of whom also had substance misuse issues.

During early prison visits as HMCIP, he had been "absolutely appalled" to find the regime was "foreign" to how he considered people with mental health issues should be treated and was "shocked" to discover this.

Further, he commented:

When the NHS started dealing with the Prison Commission, it was believed this would result in services way in advance of anything the NHS could do but the deliberate exclusion of prison healthcare when the NHS was founded [to him] made no sense.

He also said that the needs of short and long-term prisoners were completely different, and that detrimental compromises, rather than positive ones, had been made.

Concerned by the lack of equivalent care, in 1996 he produced, and then disseminated widely, his influential paper *Patient or Prisoner?* This determined the Government to focus attention on the healthcare needs of prisoners, leading eventually to the transfer of prison health to NHS responsibility (Department of Health, 2003b; Department of Health, 2003c). Here too, there was criticism. Leading up to the transfer, he argued the “preparation for NHS treatment should have been joint work with the Home Office”. He felt strongly that a direction for healthcare in the prison service should have been issued. In particular, there had been “no guidance, protocols or transfer notes”.

This criticism suggests that, despite an intense period of investigation and policy development which followed, a detailed understanding of how equitable provision should be achieved was not communicated with prison and healthcare services. It is impossible to determine from the policy literature whether this resulted from a failure to define what was meant by this, or a fundamental lack of understanding, on the part of the Government regarding what actions were required. It may also have been no more than an example of a lack of instruction and support.

Phase Two of the policy literature concludes with HMCIP’s criticism of health care delivery to English prisoners. This cannot be underestimated, as it could be argued that the *Establishment* was being attacked by one of its own. At a theoretical level, HMCIP demonstrated significant power to influence, and had attracted clear political attention. Further, it is suggested here that these actions support Cawson’s (1982) assertion that those with a close

strategic alliance can be particularly influential with the government of the day.

In terms of healthcare policy, the ramifications of these activities were profound. Phase Three will now commence with a consideration of a variety of published material during this final period and explores whether the challenge to deliver equitable provision for this new patient population was, in fact, a realistic endeavour from the outset.

1.6 Health Policy Phase Three

Table 3

Time Line Phase Three 1997-2010

The table below shows the third phase of the health policy timeline.

Philanthropy and Concern for Prisoner Welfare	Prison Specific Policy and Recommendations	Wider NHS Policy, NSFs and Strategies
	1997 <i>Provision of Mental Health Care in Prisons</i>	1997 White Paper <i>New NHS, modern dependable</i>
		1998 Green Paper <i>Our Healthier Nation: a contract for Health</i>
		1998 <i>A First Class Service: Quality in the new NHS</i>
	1999 <i>Future Organisation of Prison Healthcare</i>	1999 <i>Saving Lives: Our healthier nation</i>
		1999-2005 National Service Frameworks
	2000 <i>Nursing in Prisons</i>	2000 <i>NHS Plan: A plan for investment, a plan for reform</i>
	2001 <i>Prison Health Policy Unit & Task Force Annual Report</i>	
	2001 <i>Changing the Outlook</i>	
	2002 Health Improvement Plans	
	2003 <i>Important Changes to NHS Responsible Commissioner for Prisons</i>	
	2003 PSO 3200 Health promotion in Prisons	
	2003 <i>Guidance on Developing Local Prison Health Delivery Plans</i>	
	2003 Prison Health Handbook	
	2004 <i>Sign Posting to Prison Health</i>	2004 <i>Choosing Health: Making Healthier Choices Easier</i>
Public Health Phase Three	Public Health Phase Three	Public Health Phase Three

Responsibility placed on individuals	Responsibility placed on individuals	Responsibility placed on individuals
	2006 <i>Prison Health Partnership Survey</i>	2006 <i>Our Health, our care, our say: A new direction for community services</i>
	2008 <i>Improving Health, Supporting Justice</i>	2008 <i>NHS in : The Operating Framework for 2009/2010</i>
	2008 <i>Offender Health & Social Care Strategy Data Report</i>	
	2009 <i>Prison Health Performance Indicators Guidance Booklet</i>	
Concern for prison overcrowding		2010 <i>The NHS Constitution for England</i>
	Prison population has risen by 85% since 1900 to 74,706 standing at 800 places above the useable operational capacity	

The third and final policy period commences with the Department of Health's acknowledgement that there was a specific need to respond to *Patient or Prisoner?* (1996). Additionally, in the autumn of 1997, the standing Health Advisory Committee to the Prison Service published a report *The Provision of Mental Health Care in Prisons* (Health Advisory Committee for the Prison Service, 1997). This document criticised the uncoordinated way in which mental healthcare to prisoners was formulated and delivered, contributing to HMCIP's earlier criticism.

In response, and charged with the brief to address HMCIP's paper, the Home Secretary and the Secretary of State for Health agreed to establish a Prison Service and National Health Service Executive Working Group. This is the first indication, in the health policy literature, of these two bodies combining at national level in order to generate system-wide transformation of prison healthcare. This indicates the importance which the Government placed on this agenda.

For the first time, this Group was charged with developing proposals which could transform prison healthcare to something achieving equivalence to that delivered to the general population. Specifically, the Group was asked to consider whether prison health should be transferred to the responsibility of the NHS (as cited in Joint Prison Service and National Health Service Executive Working Group, 1999, p. 48). Arising from this, in September 2002,

Ministers announced the decision to transfer the budgetary responsibility for prison health from HM Prison Service to the Department of Health.

The Joint Prison Service and NHS Executive Working Group's deliberations were timely, as they had taken place during a time in which the NHS itself had set in train a number of important national initiatives. These were intended to improve NHS service provision and, by so doing, the health of the population (Department of Health, 2000a). This extensive body of health policy brought with it considerable challenges for imprisoned patient care, including the wider pressure on prison estate. These matters will be returned to in sections 1.7 and 1.8 to follow. The subsequent sub-section addresses aspects of the prison population, as these are relevant to the healthcare required.

1.7 The Prison Population in England

Whilst acknowledging that imprisonment presents a unique opportunity to improve the health of the sick, successive Governments have also recognised that prisons present particular challenges in this regard (Department of Health, 2002a). Most recently, this is manifest in a current severe level of overcrowding. This phenomenon is relatively recent in English prisons, but the data shows a steady upward pressure. The literature for England and Wales indicates that prison numbers increased slowly over the past century. In 1900, the offender population was 14,459 males and 2,976 females (Ministry of Justice, 2009, p. 18). Since 1993, the increase has risen sharply by 85%, and passed 80,000, for the first time, in December 2006.

Another exceptional situation occurred on 22nd February 2008 when the prison population exceeded the total operational capacity for the first time in history. This operating margin allows for the requirement to provide separate accommodation for some prisoners, e.g. conviction status, sex, age, or single-cell risk assessment. This breach, it has been argued, exposed the vulnerable prisoners to abuse and physical attack (Prison Reform Trust, 2009b).

In October 2009, the prison population was 84,706, meaning 800 places above the useable operational capacity (Ministry of Justice, 2009, p. 2). This has led to pressure on all aspects of service delivery, and a heightened level of anxiety for the welfare of prisoners (Prison Reform Trust, 2009b). It is within this landscape that prisoners' rights to equitable healthcare must be delivered.

1.8 Prisoners' Rights to Equitable Healthcare

Here, it is important to reflect that these issues belong within a wider international context. Moreover, the Government's autonomy to determine both prison, and wider policy, is seen to be increasingly impacted by decisions and actions of bodies such as the European Parliament. Consequently, it is essential to consider health policy development within the wider legislative context.

Here, the *Convention for the Protection of Human Rights & Fundamental Freedoms* (Council of Europe, 1950), in particular, is a key piece of legislation. This bestowed on prisoners the same right to justice as that of the external population. As a result, the right to fair treatment was established internationally. Prisoners' (although not specifically mentioned) entitlements to equitable health provision were also strengthened in 1981 when the WHO published its report, *Global Strategy for Health for All*, which demanded equity in health for people in every country.

The right to equitable treatment, clearly articulated in the legislation, required suitable mechanisms through which the Government could discharge its healthcare responsibilities. Specifically in England, the decision was taken to drive the consistency and quality of equitable service provision through NSFs.

Consequently, fair access to equitable treatment can be clearly seen in both the international and European legislation. It is also present within the NSF for Mental Health, and Joint Prison Service and National Health Service Executive Working Group's report (1999). These essential elements were

clear drivers for the improvement of patient health, described in the White Paper *The New NHS modern, dependable* (Department of Health, 1997), in the Green Paper *Our Healthier Nation: a contract for health* (Department of Health, 1998a), and in *A First Class Service: Quality in the new NHS* (Department of Health, 1998).

Taken collectively, these papers promoted organisational development of the NHS, replacing the internal market with a system of integrated care, based on the promise of fair and open access. These were the principles on which the NHS itself had been formed, and laid the wider NHS policy foundation for equitable healthcare delivery to prisoners. The limitations of this policy intent, however, has previously been criticised in this chapter (Bridgwood and Malbon, 1995; Smith, 2000; Whitehead, 1988).

Subsequent to the deliberations of the Working Group, a number of other publications are considered relevant to the improvement of prisoner health: *Saving Lives: Our healthier nation* (Department of Health, 1999b); *Reducing health inequalities: an action report* (Department of Health, 1999a); *The NHS Plan: A plan for investment, a plan for reform* (Department of Health, 2000a); *Choosing Health: Making Healthy Choices Easier* (Department of Health, 2004); *Our health, our care, our say: A new direction for community services* (Department of Health, 2006a); *High Quality Care for all: NHS Next Stage Review – Final Report* (Department of Health, 2008b); *The NHS in England: The operating framework for 2009/2010* (Department of Health, 2008h). Together, these documents explicitly challenged NHS commissioners, providers and individual patients to avoid ill health through poor lifestyle and inequality, where it existed.

It is important to briefly consider, here, that the lack of common ground between the views of social democrats and neo-liberals in relation to healthcare policy development and state intervention in the lives of individuals became particularly visible in healthcare policy development. Prime Minister Tony Blair replaced Margaret Thatcher, and later John Major's Government during which health policy was characterised by the internal market.

Now, health policy was instead developed within an ideological framework of *The Third Way*. This, it was argued, represented the manifestation of an attempt to “avoid the problems of too much state control and the chaos of market forces” (Taylor and Hawley, 2010, p. 31). Further, it was intended that the State would establish the strategy and direction for healthcare policy. It would not, however, directly intervene at a local health delivery level. Here, individual health experience would be driven instead by patient choice. But whether patients as consumers would benefit as a result of this choice is a matter of academic debate (Mol, 2008). This marketisation of healthcare, Mol (2008) further asserted is far more than a simple relationship between an individual and their clinician. Here, patients’ ability to effect choice is impacted by their openness to the influence of other patients/patient groups and their individual circumstances (Mol, 2008, p. 16).

Also at this time, the New Labour Government matched Political activity with financial growth unprecedented in healthcare history. The NHS was predicted to grow by one-third, in real terms, over a five year period (Department of Health, 1997). Power to deploy staff and resources, and pool budgets with local social care services, would be devolved to high performing NHS Trusts, supporting the Government’s localism agenda in which key decisions were moved away from central control (Department of Health, 2002b). Patients too were given the right to be heard regarding the quality of local health services. This new patient-centred approach to NHS provision would become a feature in all NHS policy to follow (Department of Health, 2004). Yet, the imprisoned patient voice during this period is notably silent and no verification is apparent regarding attempts to involve them in the shaping of these new arrangements. This, it could be inferred, was an opportunity lost.

The underpinning philosophy of this activity was a belief that the NHS was unfit for the 21st Century (Department of Health, 2000a). This Plan became the bedrock on which the Government’s ten-year NHS Modernisation Agenda would later be built. Despite this, the NHS Plan attracted criticism aptly summarised by Evans (2004, p. 68) who argued that from a Public Health perspective, “the NHS Plan was disappointing”.

During this period, imprisoned patients were, for the first time, mentioned in mainstream NHS policy *Choosing Health: Making Healthy Choices Easier*, (Department of Health, 2004). It is somewhat surprising, given the poor state of the health of this population, and a return to social democratic values, that it took eight years for this to occur, post-Ramsbotham's (1996) paper. In addition, *Choosing Health*, (Department of Health, 2004), would signal Phase Three of the Public Health Agenda which was based on the WHO's vision of broad-based health promotion as a means for health for all. Responsibility for health improvement was now, for the first time, firmly placed in the hands of individuals. This White Paper, nevertheless, was also widely criticised. In particular it was argued that it "failed to address the fundamental social and economic inequalities that persisted, and in some respects deteriorated, under the Labour government" (Baggott, 2000, p. 72).

As previously discussed, five sub-themes are evident in the policy literature. This final phase of the timeline presents an intensely active period of health policy development unprecedented in NHS history. This will be considered in the section to follow.

1.9 Healthcare Policy Sub-themes

Table 4

Wider NHS Policy Sub-themes

The following table shows the policy sub-themes identified.

	Sub Theme
1	Equitable Healthcare Provision
2	Integrated Care
3	Partnership
4	Shared national priorities to reduce health inequality - driven through NSFs
5	Staff

1.9.1 Equitable Healthcare Provision

This initial policy sub-theme highlights the Government's stated commitment to provide equitable services for all patients. This intent preceded the transfer of prison healthcare to NHS responsibility as patients in England had been promised high quality care as early as 1998, regardless of where they lived (Department of Health, 1998).

A First Class Service: Quality in the new NHS heralded the introduction of NSFs. The direction provided by the NSF for Mental Health was valuable as it was commonly accepted that one in six people has a mental health condition in the United Kingdom (Yorston, 2004). The figure for prisoners is thought to be considerably higher (Department of Health, HM Prison Service and The National Assembly for Wales, 2001, p. 3). Standard One of the Framework is helpful, as it places a specific requirement on the NHS to promote mental health and social inclusion for all. It, therefore, challenged discrimination against individuals and groups affected by mental health conditions.

The NSFs also acknowledged that some patient groups were particularly vulnerable. Specific targeted resources were demanded in an attempt to improve this position. As such, high quality, cost-effective services (Department of Health, 1998) were promised targeted at key groups (Department of Health, 1999). Additionally, services were required at all times to be *broadly equivalent* to those provided to the external community (HM Prison Service and Department of Health, 2003).

This policy commitment to address specific vulnerable or disadvantaged patient groups was developed further in two key documents. These established the Government's strategy for health, *Saving Lives: Our healthier nation*, and *Reducing Health Inequalities: An Action Report* (Department of Health, 1999). Published jointly, these reports drew attention to the high levels of cancer, coronary heart disease and stroke, accidents and mental health, already targeted through Government policy (Department of Health, 1998). Combined, these documents represented a route map to reduce health inequality in the patient population and defer some 300,000 deaths. It

is possible to conclude that the achievement of equitable health status for the vulnerable may require higher levels of services. This thesis would posit, therefore, that equality for some may be considered inequitable in the appreciation of others.

The recommendation to transfer prison healthcare to NHS responsibility, in the same year, was timely. Although prisoners were not explicitly mentioned in mainstream healthcare policy until five years later (Department of Health, 2004) this does not mean that earlier policy was not intended to apply to them. No verification exists in the policy to indicate this and, at worst, prisoners were an oversight. Prison healthcare had the good fortune to transfer to NHS responsibility at a time when there was a clear Government commitment to improve health care services and the NHS. It was later argued, however, that despite this ambitious programme, a reduction of health inequalities prevalent in society was yet to be realised (Paton, 2006).

Coincidentally, the third phase of the Public Health Agenda also emerged during this period, and was fully aligned with the WHO's vision of broad-based health promotion as a means of achieving health for all. For the first time, Public Health in England charged individuals, rather than society, with responsibility for improving their own health (Department of Health, 2004). For prisoners, Prison Service Order (PSO) 3200 simultaneously placed a responsibility on the Prison Service in partnership with the NHS, to deliver services broadly equivalent to those in the general community. Moreover, these policies combined to create a framework within which, at least at a theoretical level, prisoners could take the necessary steps towards health improvement.

The delivery of the intended fair provision was planned to be monitored through data derived from three-year Health Improvement Plans (HImPs) demanded from each locality (Department of Health, 2002). Later, these would be strengthened through the publication of the *Prison Health Performance Indicators Guidance Booklet 2007/2008* (Department of Health, 2009) and prison quality indicators (Department of Health, 2008f). It was the Government's intention that data would now be collected on a range of health-related issues. Foremost, performance was expected to be raised to

that equivalent to the standard in the wider NHS. Although participation was voluntary for prisons and PCTs, it was later reinforced when the *Offender Health and Social Care Strategy Data Report* was published by the DH (2008d, 2008e).

Significantly, the effectiveness of equitable provision to prisoners would now, for the first time, be measured (Department of Health, 2008e). Implemented successfully, this requirement could contribute towards Gunning-Schepers (1989) demands that the effects on access, utilisation and quality of health provision should be measured in terms of its specific impact on health disadvantaged groups.

1.9.2 Integrated Care

NHS policy indicates that the delivery of equitable healthcare faced numerous challenges. One of these was the fragmented nature of healthcare delivery at that time. Recognition of the importance of integrated provision had been highlighted in *Patient or Prisoner?* (Ramsbotham, 1996). The author had argued that it was illogical that, during imprisonment, healthcare was provided through separate channels, as the majority of inmates would return to the community upon release. Without integration, he said, it would be “impossible to achieve equality and continuity of care” (Ramsbotham, 1996, p. 8). The central policy intent would, therefore, fail.

The benefit of service integration was further recognised by the Joint Prison Service and NHS Executive Working Group. The Group felt imprisonment provided a valuable opportunity to treat people who were recognised to suffer ill health and had previously been difficult to reach. Later, service integration could provide the means through which individuals could be assisted to function to their maximum potential upon release (Joint Prison Service and NHS Executive Working Group, 1999, p.5).

The societal value of services combining is clearly articulated in the policy so far presented. For the first time, there is also a strong indication of strategic thinking, demonstrated by the 2003 unification of the Policy Unit and Task Force into the single Prisoner Health Unit. Service integration was central to its objectives, with a stated intent to benefit prisoner health in two ways:

firstly, to improve the standard of prison health services through greater integration with the wider NHS and, secondly, to improve through care utilising effective links with health and related community services. Prison Health would also prioritise service developments through improved mental health in-reach teams, primary care provision and workforce development. A number of these initiatives would be later questioned and this important debate will be returned to in Literature Review to follow.

It must be asked why only mental health matched the health priorities previously established in *Our Healthier Nation: a contract for health* (Department of Health, 1998a). This suggests a lack of synchronisation with National policy intent that can be found in other areas of policy development also. For example, recognition of a causal link between health and social care need and offending behaviour was later highlighted. This was explicitly stated in *Improving Health, Supporting Justice: A Strategy for Improving Health and Social Care Services for People Subject to the Criminal Justice System* (Department of Health, 2008c). Arising from this, services would now be challenged to identify ways in which both health and social care provision could be improved. Previously a neglected area in the policy literature, for the first time, social care provision to prisoners achieved focused Government recognition.

The importance of this acknowledgment cannot be underestimated, as it is argued internationally that health services alone cannot remove inequity for the health disadvantaged. Social care also must be part of the solution (Whitehead, 2000). For prisoners, little literature on this subject exists, demonstrating that this is an under-researched area.

1.9.3 Partnership

Partnership was also recognised as essential to drive forward service reconfiguration and improvement (Department of Health, 1997; Department of Health, 2002; Department of Health, 2003a; Department of Health, 2004; Department of Health, 2008h; Joint Prison Service and NHS Executive Working Group, 1999; Prison Health Policy Unit and Task Force, 2001).

The first of these documents, *The NHS Plan* (Department of Health, 1997), had replaced the NHS internal market with a system of integrated care. The proposed new system would be built on partnership evidenced through the production and delivery of Health Improvement Plans (HIMPs) already introduced.

The NHS Plan also heralded the establishment of Primary Care Groups (PCGs) which would commission local health provision based on the belief, at that time, that primary care professionals understood the needs of their patients. This is significant because later PCGs would evolve into PCTs, namely the bodies charged with commissioning healthcare services for prisoners. The belief that General Practitioners (GPs) *know best* would again be re-emphasised with a later change in Government. The following year, *Our Healthier Nation: a Contract for Health* (Department of Health, 1998a), containing proposals for partnership between Government, local organisations, and individuals, was published.

These developments were not without criticism. Paton (2006, p. 6), for example, argued that as a result of “an absence of meso-level institutions... central government has to issue disjointed commands down different vertical ‘silos’ [*original emphasis*] of the Department of Health”. PCTs, he argued were “cumbersome and counter-productive devolved institutions”, which existed primarily to provide the Government with a “tortuous ‘backdoor’ [*original emphasis*] means of planning health services” (Paton, 2006, p. 6).

Closing the health gap between the socially privileged, socially excluded, and least well off members of society was also prioritised. An ambitious ten-year target was set in order to:

- reduce deaths from heart disease and strokes by a third, and cancer by a fifth in people under 65 years of age,
- reduce by a sixth deaths from suicide of people with mental health issues,
- reduce accidents by a fifth.

Benefits of effective partnership were further emphasised the following year by the Joint Prison Service and National Health Service Executive Working Group. It concluded that a partnership approach would lead to organisation-wide benefit, and would make improvement less reliant of the work of single individuals. Reflecting on the benefits to offender health since the publication of *The Future Organisation of Prison Health Care* (1999), the Task Force argued that prisoner health had assumed a higher national priority having previously been a neglected issue. Recognising that this was not sustainable, a national partnership approach was taken to the development of prison services (Prison Health Policy Unit and Task Force, 2001). The Task Force recognised that leading this at national level was its own responsibility.

The importance of a national strategic approach was, therefore, clearly articulated. National leadership alone could only establish the policy framework. At the local/operational level, partnership between prisons and PCTs was also required if services were going to improve for imprisoned patients. The co-creation of HImPs (Department of Health, 2002), it was intended, would help to reduce variation in health needs in prisons. Published at the same time *Shifting the Balance of Power* would move the lead responsibility from Health Authorities to PCTs as successor organisations from April 2002. Again the need for effective partnership was emphasised to ensure the transition was conducted as effectively as possible. Prisons, it was also hoped, would be included in future discussions about local health services and resourcing priorities, driven by a joint action plan and integration of the Prison HImP within that of the wider community.

Collectively, this cluster of healthcare policy established the strategic policy intent (Department of Health, 2003a) to achieve mainstreaming and integration of prison health within the NHS and Prison Service by April 2006. Underpinning principles for the new arrangements were set out in the national governance framework, jointly published by the Department of Health and HM Prison Service. There was a clear expectation that prisons and PCTs would work together with the “spirit of partnership” (Department of Health, 2003a, p. 1) to deliver the promise of improved health and wellbeing.

1.9.4 Shared national priorities to reduce health inequality - driven through NSFs

The first NSF was published in 1999, the same year as the Joint Prison Service and National Health Service Executive Working Group produced its report, *The Future Organisation of Prison Healthcare*. Amplifying their individual benefit, these documents outlined together a valuable series of entitlements, setting a direction for the implementation of prison healthcare.

An NSF for Mental Health had not, however, been specifically intended for imprisoned patients, and its value to this group could be no more than a fortunate coincidence. It was later successfully argued that the Framework applied equally to this population (Department of Health, HM Prison Service and The National Assembly for Wales, 2001) strengthening the idea that prisoners were not the intended target. The NSF for mental health, and subsequent NSFs, therefore, provided a mechanism for the implementation of equitable healthcare policy, each establishing high quality models of care. This emphasis on the vulnerable was of particular value to prisoners as this group is amongst the most health disadvantaged in the country (Fazel *et al.*, 2001; Lurigio, 2002; Yorston and Taylor, 2009). This will be returned to in the literature review to follow.

It was also clear that wider NHS priorities were intended for inclusion with local plans, and that planning arrangements for prison health were required to be fully integrated and mainstreamed from 2006/07 (Department of Health, 2003a).

1.9.5 Staff

When, in 1999, the Prison Health Policy Unit and Task Force published its Annual Report *The Future Organisation and Delivery of Prison Health Care* (Joint Prison and National Health Service Executive Working Group, 1999) had identified considerable variations both in the organisation, funding, delivery and quality of healthcare for prisoners, as well as within the interface with the NHS. A common criticism of prison healthcare, which was endorsed by the Working Group, was professional isolation of staff from the mainstream of the NHS. Some nursing care was found to be delivered by

non-nurse trained staff, and nursing care, more generally, did not meet NHS standards. Difficulties with recruitment and retention were also widespread.

An important document published in response was the *Nursing in Prisons: report by the working group considering the development of prison nursing with particular reference to health care officers* (HM Prison Service, The National Assembly for Wales and NHS Executive, 1999). This supported the recommendations and endorsed the lifting of the moratorium on the recruitment of healthcare officers. This effectively acknowledged that prison healthcare should be delivered by a range of qualifications and competencies suited to the health needs of imprisoned patients. This reflected wider practice within the NHS, particularly those outlined in the DH Nursing Strategy, *Making a Difference* (Department of Health, 1999c).

Broadly, the document argued that Prison Healthcare services must make best use of the skills currently available, signalling a closer alignment with the wider NHS Modernisation Agenda. The authors proposed that improvements in the quality of prison healthcare should be based upon occupational standards reflecting good practice, and that these should be endorsed by all the key stakeholders. The report made 35 recommendations, amongst which were those proposing that the Prison Service should commission a national occupational standards framework for prison nursing, and that a cohort of 20 existing healthcare officers should contribute to the development of the occupational standards going forward. The authors further stressed that all existing healthcare officers should then be offered the opportunity to achieve this qualification. As a proportion of prison healthcare staff, these recommendations have particular relevance for prisoners.

Additionally, Lord Darzi (Department of Health, 2008) argued that, in order to address this, frontline staff must be central to this process. Variation in the quality of care given to patients would have to be tackled. He believed that the programme of reform to date had been unevenly applied, and pointed to rising patient expectation and service demand driven by demographics. To meet these, Darzi said, the NHS needed to anticipate and respond effectively. High Quality Care for all: NHS Next Stage Review – Final Report (Department of Health, 2008), as in previous reviews, he felt, NHS frontline

staff had been insufficiently involved. In future, the intention was that staff themselves should play a significant role in healthcare service improvement.

The fundamental role that staff play in bringing about equitable health provision cannot be underestimated and Whitehead (2000, p. 9) had previously argued that:

[...] equal quality of care for everyone, also implies that providers will strive to put the same commitment into the services they deliver for all sections of the community... Inequities arise in this case when professionals do not put the same effort into their work with some social groups as with others.

Without this support, prisoner healthcare may not achieve its ambitious improvement agenda. This, and the other essential elements for success outlined throughout this chapter will emerge within the methodological framework selected for this work to follow.

1.10 Conclusion

This policy narrative shows that, despite the success of philanthropic endeavour to improve healthcare provision for prisoners the advances in medical practice did not come without consequences, many of which were unintended. Amongst these, the medical model of treatment and resultant pooling of resources in the hands of a small number of specialist hospitals weakened the ability of the most disadvantaged to benefit, and the Inverse Care Law (Tudor Hart, 1971) in England existed.

The underlying ill health of prisoners and their inequitable access to healthcare treatment is clearly acknowledged (Joint Prison Service and National Health Service Executive Working Group, 1999). As a result, Government recognition, focus and resource, within a legislative framework demanding equity for prisoners, signalled clear policy intent to resolve this.

The prison specific healthcare policy presented here is positioned comfortably within the wider ten-year NHS Modernisation Agenda, intended to close the

gap between the health-experience of target patient groups, this was not, however, without criticism (Baggott, 2000; Evans, 2004; Paton, 2006).

Further, it must also be questioned how embedded this group actually was in mainstream Government thinking, despite the undoubted attention and espoused commitment to improve prisoner health. This question arises because, despite a period of intense policy activity and undoubted focus on this subject, prisoners did not specifically appear in mainstream NHS policy until 2004 (Department of Health, 2004). Coincidentally, this was the point when prisoner ill health was also causally linked with offending behaviour (Social Exclusion Unit, 2002). Whether this too was a factor in the Government's endeavours must also be considered.

The health policy literature suggests that, without the essential underpinnings at a micro-level, Healthcare Policy has the potential to fail. Clear support was found of key individuals' effectiveness in legitimising the plight of the imprisoned sick (Howard, 1784; Ramsbotham, 1996) and, at a theoretical level, prisoners' health has a clear opportunity to benefit from a series of key enablers to include:

- Government commitment to change
- HImPs
- JSNAs
- Legislation
- NHS policy
- NSFs
- Prison lobby and philanthropic endeavour
- Prison specific policy, instructions and orders
- Public Health Agenda
- The National Working Group

Supported by NSFs, as key drivers for fair and equal treatment, and by local planning arrangements, PCTs had the necessary powers and resources to achieve equitable provision for their new patient group. Here too, these groups were criticised (Paton, 2006). It must be asked, therefore, how realistic was this expectation and, given that prisoners were not involved in

consultation leading up to the transfer, how aware were PCTs of their numerous underlying health needs? Without this, and in the absence of national data detailing the health of the prison population, a baseline for the current health status and service requirements cannot be established.

The sub-themes drawn from the NHS policy presented in Phase Three, underline the considerable and extensive array of responsibilities placed on the shoulders of these newly established bodies. Alongside equitable provision, PCTs had also to deliver a bewildering number of other things to include: service integration, service commissioning, effective partnership, staff development and involvement, as well as the commissioning of primary care services for the wider population. Together, these essential elements, if deployed effectively, promise the opportunity to create system-wide change. This, however, can only happen with clarity of purpose and strategically effective commissioning. In their absence, there is a danger that, despite the energy and focus of all, un-integrated commissioning may result in disintegrated care.

Driven effectively through JSNAs and HImPs, service reform for prisoners becomes a real possibility, but the planning system will only be as good as the information fed into it and from which decisions can reliably be made. Without it, real improvement in prisoner health is not likely to be achieved on anything other than an ad hoc basis.

This study will next examine whether the considerable effort to bring about effective change, driven by the NHS policy outlined in this chapter, was successful.

The following chapter presents the literature highlighting the chronic ill health of this population within a theoretical framework of Public Health for England. Finally, in order to frame Chapter Two for the reader it is useful to state the overall research question for this work.

1.11 Initial Research Question

This question is:

What is prisoners' experience of healthcare in England post-transfer to NHS responsibility, and has the policy promise of equitable healthcare provision been achieved in the penal setting for this patient group?

Here, it is useful to re-justify the research question as there is a paucity of literature that illustrates prisoners' experience of equitable healthcare post-transfer to NHS responsibility. This work addresses this important gap.

CHAPTER TWO: LITERATURE REVIEW

I hope that the paper will soon lead to full, frank and meaningful discussions between all concerned in the National Health and Prison Services. It recognises that time will be needed to ensure that all relevant implications have been taken into account. We believe that all concerned can only benefit from taking part in the discussion process, the aim of which must be to ensure the delivery of urgently required, genuine and lasting improvements, as soon as possible. We in the Inspectorate look forward to contributing to that process

Ramsbotham (1996).

2.1 Introduction

The overarching topic of this critical literature review is the health of prisoners in England. It will consider the literature pertaining to this broad field of academic and healthcare debate, and evaluate evidence regarding equitable healthcare delivery within the Public Health Framework, as introduced in Chapter One. This review is structured into five sub-sections: health promotion, health education, disease prevention, healthy settings and prisoner health. The final section concludes by highlighting a number of noteworthy theoretical and operational challenges for those charged with the effective implementation of the Public Health Agenda in English prisons. The paucity of first-hand NHS imprisoned-patient literature is identified as a gap in the literature. This, together with the healthcare policy challenges identified in Chapter One, provide the foundation from which this study was developed.

As appropriate for academic literature reviews, this content is not merely presented in a descriptive sense; the reports, government documents and other material are included and, indeed, discussed critically. It is worth noting that literature published post July 2010 is not included. Moreover, this literature review must include broad Public Health debates and also prison-

specific research, reports and literature. These two strands are presented and discussed in tandem throughout. This is due to their combined nature and the consequent alterations in prison healthcare that are salient for this thesis. This parallel review of Public Health and prison specific literature is justifiable, as the combination of these two bodies of literature addresses the knowledge base required for this thesis. This chapter commences with a debate about the nature of prisoner health.

Although prisoner health has been studied by numerous researchers, their works vary greatly in nature. The overwhelming majority of work is discipline-specific (Adams, 2002; Brown and Fahy, 2009; Latimer *et al.*, 2005; Turner, 2000), or epidemiology specific (Cashin and Newman, 2009; Collica, 2002; Lin and Mathew, 2005). This is suggestive of a bias to the detriment of studies, such as those conducted by Condon *et al.*, (2008) and Pollock (2006), which are more generic in nature, but very limited in number. This is inopportune, as studies of this kind are of particular value to this research as it considers the impact of health policy making, and alterations on the experiences of this broad population.

Specific areas for prison health research vary, for example aetiology versus treatment outcomes, prisoners' experiences of multiple and/or complex physical and mental health problems in the penal setting. However, the requirement of healthcare attention is a theme which runs throughout these works.

The concept of health is widely defined and disputed by a myriad of divergent academic and medical sociologists, as well as other clinicians. The definition of health selected for this review is that promoted by the Ottawa Charter for Health Promotion (World Health Organisation, 1986, p. 3), which identifies health as more than the absence of illness and disease:

Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to tackle decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates the conditions that allow the attainment of health by all its members.

This definition, as opposed to any other, has been selected, despite criticism (Baggott, 2000), because it aligns closely with a central pillar of Governmental healthcare improvement policy, *Choosing Health: Making Healthy Choices Easier* (Department of Health, 2004). Moreover, it is also important for the prison setting, as prisoners are incarcerated in the closed environment that affects health. Crucially, this thesis highlights the importance of the specific prison context for this has wide-ranging implications for health policy. Here, the importance of health-related choices made by individual citizens is argued to be fundamental to health improvement and wellbeing. However, the reality of choice as experienced by patients has also been a subject for debate as discussed in Chapter One (Mol, 2008). Specifically for the imprisoned, the concept of the freedom to exercise patient choice sits uncomfortably within the secure environment of prison.

It has been asserted that equitable healthcare provision is similarly complex, and is more than “buffering the health-damaging effects of poverty and marginalisation” (Braveman and Gruskin, 2003, p. 540). These authors posited that a lifetime’s damage caused by abuse and poverty must first be tackled if equity in health is to be achieved. Prisoners could be considered to suffer a double burden here, as a result of these aforementioned health detriments in tandem with their existence and confinement in the penal setting. Uniquely, this population is both patient and prisoner. Rutherford and Duggan (2007), however, warned that *complexity* is a term which is too easily used to cover wide ranging health agendas. Supporting Hammett *et al.*’s (2001) findings, mental illness and substance misuse should also be addressed and these are salient issues in the prison context.

A number of key determinants of ill health are captured within the framework for national health priorities, and targets outlined in the Department of Health’s (2004) first ever White Paper on Public Health *Choosing Health: Making Healthy Choices Easier* presented in the previous chapter. Despite its attendant criticism (Baggott, 2000; Evans, 2004; Paton, 2006) the White Paper outlined specific conditions prioritised for targeted intervention. Further, it announced the Government’s intention to move Public Health from a medical model of healthcare delivery. Now, instead, the focus would be health-related choices made by citizens, hereby, introducing the third and final phase of the

Government's ten-year NHS reform journey. Instead, the focus would be on the underlying social and structural determinants of ill health. Here, for the first time, responsibility for the improvement of Public Health would rest in the hands of individuals (Department of Health, 2004). Notwithstanding the laudable intent of the White Paper, it was argued that little incentive could be identified to prioritise Public Health (Hunter and Marks, 2005).

In relation to these changes, Hayton and Boyington (2006) warned that this specific White Paper and other Healthcare policies could appear as a strategic master plan. In reality, the authors argued that policy implementation is somewhat more "messy" (2006, p. 1730). If we are to accept the argument that healthcare policy can, at times, appear illusory, the methodological framework for this work must be capable of surfacing the constructed reality of participants and wider stakeholders taking part. Further, this separate line of debate complements the *tectonic healthcare policy* metaphor, and law of unintended consequences (Easton, 1953) theories offered in the opening chapter of this thesis.

2.2 Theoretical Framework

Public Health in English prisons is outlined within a *Whole Prison Approach* published in the strategy *Health Promoting Prisons: a shared approach* (Department of Health, 2002a). Together with PSO 3200 *Health Promotion*, the Public Health Policy framework for English prisoners is clear. Health promotion, health education, disease prevention (sometimes referred to as primary, secondary and tertiary), and healthy settings are the key elements of this framework.

Accordingly, the impact of these on prisoner health will form the theoretical framework for this review presented in Figure 3 to follow.

Figure 3

Theoretical Framework Public Health



Figure 3 illustrating the impact four key elements of Public Health on the health of prisoners.

The processes of searching, accessing, and selecting of relevant narrative are now outlined in order to demonstrate the approach used for this literature review.

2.3 Rationale for the Selected Literatures

The literature has been collected and then reviewed via two distinct, yet inter related, approaches:

2.3.1 Opportunistic Searching

Healthcare Policy publications, reports and literature from both Government and wider academic sources were collected from key sources and websites. Sources are listed in Appendix B.

Literature was analysed in order to identify reference lists to explore additional, potential new material. This literature acted as a gate-keeper to this academic, government and health-related field of literature. These documents were then considered for their relevance and application in the literature review. This material then formed the baseline for the main review.

2.3.2 Bibliographic Database Searches

A computerised database search then followed as the second, and main, approach. The aims of the search strategies were dual: firstly, to ensure that all relevant material was included and, secondly, to generate a high recall of material. This was intended in order to ensure that all relevant items for literature analysis were included. Two broad exploratory questions were formulated as the basis for initial considerations. These were:

- What is the evidence for the standard of health amongst the prisoner population in England?
- Is there evidence of equitable NHS care and treatment for imprisoned patients in England?

The search terms evolved via discussion between the researcher and research supervisors, and by scanning background material. The literature review shaped the initial stages of this study to examine prisoners' experiences of healthcare in England.

Academic databases were searched using UNLOC (University of Nottingham On-Line Catalogue). A full search of the Open University's on-line electronic members' library resource employed search terms related to prison health, such as *prisoner welfare*.

Table 5
Literature Review Search Terms

The following table demonstrates the full list of search terms used for this study.

Search terms	Search terms
aged prisoners	old prisoners
alcohol & drugs	older prisoners
blood borne virus infection	prison health
BMaE prisoners	prisoner health
BME prisoners	prison palliative care
dental health in prison	prison population
elderly prisoners	prisoner demographics
electronic patient records	prisoner health complaints
equality	prisoner self harm and suicide
equitable healthcare	prisoner welfare
equity	prisoner's mental health

imprisoned patients	sexual health in prisons
inmate	women prisoners
offender	young offender

A concentrated search of relevant electronic journals was also employed at this point.

The initial phase continued until the literature was thoroughly explored. At this point, no additional studies, journals, reference lists and reports were identified, other than those already entered into the study database. Following this, an additional phase utilised both inclusion and exclusion criteria. The aim was to achieve a further reduction. Material perceived as relevant to the research questions provided the focus for this. Most papers prior to 1996 were discarded, due to the extensive sources available beyond this point and the focus of this thesis being the post-transfer to NHS care in the prison context. Documents fulfilling the previously outlined criteria were acquired in full. Manual and computerised search material identified was retrieved and duplicates were removed.

It is useful here to highlight the limitations of this literature review. For example, literature that explores the health experiences of deaf prisoners is excluded. Notably, it is not possible for this thesis to explore all areas of prisoner health. Seminal English prison ethnographies are excluded, as they do not relate to the nature of NHS provision in this setting, due to their publication dates.

2.3.3 Summary of Literature Review Methods

There is a substantial body of published work in this area. Therefore, the two-stage approach described was selected as the most appropriate way to elicit useful material. However, this approach increased the quantity of the researcher's tasks in order to ensure that potentially relevant literature was not missed. A high recall of material at the first stage of the review, requiring meticulous reduction through manual exploration, was initially driven by low precision. This resulted from the breadth of the research questions initially deployed.

Website, expert, and wider stakeholder literature was also sourced. This included unpublished studies, policy documents, Government directives, reviews and consultation papers.

2.3.4 Accessing the Literature

Throughout, the literature was considered critically. Limitations of the material, where appropriate, are highlighted, whilst also presenting key associations with policy and debate.

To frame these debates, material will now be discussed within the Public Health Policy framework, and will be applied specifically to English Prisons.

2.4 Public Health Agenda

As outlined previously, Public Health is conceptualised as a pursuit that addresses health inequalities and attempts to target resources appropriately (for maximum patient improvement). At both strategic and political levels, this agenda also reflects the Government's vision and intention concerning the suitable approach for the health of the nation. The notion of Public Health encompasses a plethora of practical, political and ethical dimensions.

Political intent, though laudable, was not without criticism and it was argued that close cross-government working on health issues enshrined in health policy was something which created specific difficulties in the UK. Amongst critics, Nigel Crisp, as the only person in England to have held the positions of Permanent Secretary of the Department of Health and Chief Executive Officer of the NHS, considered that the NHS would benefit from separation from both politics and politicians. By so doing, freed of the need to focus on the running of the wider NHS, politicians could concentrate instead on the health of the population (Telegraph Online, November 20th, 2009).

For imprisoned patients, a clear political focus on health improvement, posited above, has particular relevance. This, it could be said, requires a clarity of purpose, free from the machinations of political doctrine. Specifically for English prisoners, the 2005 prison health transfer date represents the crucial

point from which their experience of healthcare, and its impact on their health and wellbeing, should be evaluated. From this time onwards, services should (in accordance with Government policy) have been commissioned on an equitable basis (Joint Prison Service and National Health Service Executive Working Group, 1999).

Defining equity in health, however, is problematic. For Braveman and Gruskin (2003), equity in health is the systematic reduction of underlying social advantage/disadvantage within the population. Further, these authors assert that equity is an ethical principle. Whitehead's (2003) call for examination of the different rates of utilization by different social groups in order to highlight social injustice, where it exists, could be particularly valuable if it were to be implemented. Whitehead (2003, p. 9) argued that it was important that a person's opportunity of being selected for attention was facilitated through a fair procedure "based on need rather than social influence". Here too, caution is advisable, as the Department of Public Health & Epidemiology (2000) found considerable underlying confusion between the services people wanted and what, in fact, they needed suggesting an underlying flaw in Whitehead's (2003) proposal.

Some assert that the long-term chronic under-funding of prison healthcare has created an inequitable healthcare landscape which demands targeted investment particularly for those with mental health issues. The work of some, however, suggests that a person's whole-life experience is relevant to the underlying equity healthcare principles rather than an individual's state at one particular point in time (Williams, 2000). Examination of the relevant literature, would also indicate that only a limited understanding of the level of illness prevalent in this population was available and accepted (Department of Health, 2002a). Therefore, it could be argued that, even if the Department of Health had the strategic foresight to establish a coherent baseline for levels of sickness, disease and disability amongst this population, the absence of this crucial data would have prevented it. This seems an opportunity lost as, in its absence, national patient outcomes cannot be measured on a prison system-wide basis.

Moreover, an opportunity to measure or evaluate the impact of a whole health system Government health policy initiative was missed, and the benefits, or otherwise, of these new arrangements would only be able to be identified at local level. This localised assessment of prison health developments is not problematic inherently, but it is a limitation and boundary of the knowledge, complicated by a lack of *user view* research highlighted by Condon *et al.* (2007) that is recognised in this thesis.

At the point when PCTs took on the responsibility for equitable prisoner healthcare, the lack of reliable data discussed above, presented these new bodies with a considerable challenge. Yet, some limited but useful information could be available from the academic literature. Although in no sense could this be considered a detailed demographic, the underlying ill health of this population is generally accepted.

In *Understanding help seeking behaviours among male offenders: a qualitative study*, Howerton *et al.* (2007) conducted 35 in-depth face-to-face interviews with male prisoners aged 19–52, in a male Category B prison in the South of England. Distrust towards the system emerged as the most prominent theme. As a result of this, many prisoners will have seldom, if ever, accessed healthcare prior to their imprisonment (Howerton *et al.*, 2007). Although Howerton *et al.*'s study is restricted by its male only focus and limited age range, it is important as interviews were conducted both pre- and post-release. As such, participants, the majority of whom came from violent and neglectful pasts, were enabled to speak beyond the constraints of the prison regime. Distrust in healthcare services and a profound belief that health professionals did not care about them persisted beyond the prison walls.

This raises an interesting methodological challenge for this thesis which is concerned with prisoners' experiences of healthcare post-transfer to NHS responsibility. For those individuals highlighted by Howerton *et al.* and others, who have seldom used health services externally pre-transfer, it must be questioned on what basis will they be able to compare their prison healthcare experience post-transfer? These important issues will be returned to during the design, data collection and analysis sections of this work.

Although limited by the male only focus and relatively diminutive participant sample of Howerton *et al's.* (2007) work it is possible that this study could have assisted commissioners in formulating priorities against broad-based assumptions of need. Moreover, it should have had particular credibility with PCTs, having been conducted by both clinical and academic members of the Primary Care Research Network. There is no indication, however, that PCTs made use of this, or other similar material, on anything other than a limited individual basis. Indeed, there is evidence to the contrary, and they were found instead, to know little of the often urgent need of those newly in their charge (Health Service Management Centre, 2004).

In relation to prison health, it was more widely accepted, at that time, that the situation of both prison healthcare services and prisoner population health was poor relative to the general UK population (Ramsbotham, 1996). Whitehead, for example, in his report *The Health Promoting Prison (HPP) and its Imperative for Nursing* (2006, p. 123), highlighted prison nursing, as “seriously neglected and woefully lacking in structure and resources”. This work can be seen to cast doubt on Stephen Ladyman, the then Parliamentary Under-Secretary of State for Community’s, optimistic view (orally disseminated at the South West Region Prison Health Conference in 2004), of willing staff with the resources required to embrace the opportunities presented.

Notwithstanding the attendant difficulties, it was argued that, although imprisonment created significant challenges to health maintenance promotion, prevention and treatment, it did, at the same time, present a unique opportunity to treat this population (Department of Health, 2002a). The penal setting represents an apt site for health interventions for the benefit of its inhabitants. Further highlighting prisoners’ poor usage of healthcare prior to imprisonment, MacDonald (2006) similarly felt that incarceration could be valuable in improving health, above all for young offenders. MacDonald’s (2006) work, *The Health Needs of Young Offenders*, consisted of an extensive literature review of epidemiological and cross-sectional studies related to the health needs of young offenders. Although valuable to this study, in the sense that the paper presented an evaluation of an extensive body of penal international adolescent health literature, the

exploration of young peoples' own perception of how they viewed their health experience within this material was largely silent. Further, there is a bias towards young males. Thus, leaving gaps in the knowledge base for young females and those from Black and Minority Ethnic communities.

Despite these gaps, it is unfortunate that this thesis cannot address specifically the health requirements of young offenders, as the fieldwork sites do not include Young Offender Institutes. Indeed, only five young people in total will later express their opinion in this thesis as correspondents and a single young person interviewee. It is, however, worth noting here that, in certain respects, different health needs and dissimilar health issues exist for the divergent prisoner groups, such as male versus the young, in the UK's prison system. These differences may drive considerable variation in their perception of the equitability, or otherwise, of prison healthcare. The impact on provision within the penal setting is also ever present in the research literature.

Condon *et al.* (2007), for example, analysed 111 semi-structured interviews with prisoners in 12 English prisons in order to develop a conceptual framework. Through the application of this methodology, the authors argued that prisoners' underlying health needs came into conflict with the prison regime at all points along the offender pathway.

Further, the penal setting has been found to directly affect prisoners' health both positively and negatively. Massoglia (2008) used data from the National Longitudinal Survey of Youth to establish that exposure to infectious diseases and/or stress are important for understanding the long-term impact of imprisonment on health. By tackling the high rates of underlying disease, the author argued, imprisonment presented a significant opportunity to create long-term health benefit. For example, Edge (2006) had previously found that for the unborn, imprisonment can facilitate health benefit via increasing birth weight by 2g for every day spent in prison.

Here, it is crucial to consider alternative understandings of prison healthcare in order to produce a thorough and critical literature review. Although the promotion of prisoner health is pivotal to prison healthcare policy, the positive

benefit of the Public Health approach to offender health is not without criticism. In an extensive review of prison health literature, Smith (2000) alternatively believed that the Public Health empowerment agenda, although commendable, came into direct and real conflict with the penal control regime. Arguing that imprisonment added to the ill health that many people brought into prison with them, the author found that risky or health damaging behaviour, was used as a coping strategy for some. Further, the author posited that heightened interest in health promotion could, in actual fact, lead to victim blaming and the exclusion of marginalised groups. Arising from this, their exclusion from services could, ironically, be unhealthy.

More broadly, Isitt (2003), in the journal article, *Reflecting on reflective practice for professional education and development in health promotion*, argued that, unless agencies responsible for change at a societal level critically reflected on their own practice, the potential benefit of the Public Health Agenda would fail to be realised. This would happen regardless of the level of focus and activity in the field, previously outlined in detail in Chapter One of this thesis.

The accrued evidence, thus far, would indicate that prisons detain a challenging patient population, with extensive health and social need. It is also noteworthy that, with few exceptions, prisoners will have committed offences and are, as a result, punished via incarceration. The level of security they experience in Category A, B, C or D establishments, will depend on the nature and severity of the crime committed alongside risk of attempted escape. Literature pertaining to the impact these differing establishments have on prisoners' experiences of NHS healthcare provision is scarce. The impact on imprisoned patients' health experiences of such arrangements is also diminutive.

Before pre-offence and social exclusion issues for offenders are debated, it is important to consider the wider UK population and understandings of prisoners and their healthcare entitlements.

Wider public opinion is, however, more widely researched, and emerges as a further important consideration in this review. The stereotypical view of a

hardened career criminal (Blumstein *et al.*, 1986), or those who would be extremely dangerous to the public, if released, pervades British society. Fear and revulsion surrounding rare and shocking crimes committed by, for example, Beverley Allitt, Ian Brady, Myra Hindley, Ian Huntley, Harold Shipman and Fred West, can engender a profound sense of relief when the perpetrators are removed from society. In reality, extreme crimes such as these are exceptional, and very few people in England were, until recently, incarcerated for life (Ramsbotham, 1996). Society's fear and revulsion, however, cannot be easily dismissed.

In the first paragraph of his doctoral thesis in 1972, Cohen described what is now accepted as the general description of the concept of *moral panic*:

Societies appear to be subject, every now and then, to periods of moral panic. A condition, episode, person or group of persons emerges to become defined as a threat to societal values and interests, its nature is presented in a stylized and stereotypical fashion by the mass media (Cohen, 1972, p. 1).

Key to Cohen's thesis was the way in which society received much of this information, which was usually second-hand. This was later criticised by Jewkes (2004), who asserted that Cohen's work had been ambiguous in both the application of characteristics, and the terminology used, as well as his focus on the media, rather than the actual deviant behaviour. Cohen's theory of moral panic was further defined by Critcher (2009) as a disproportionate reaction to individual/group behaviour or events. It must be considered that the moral and ethical imperative to provide equitable healthcare services to prisoners may bring it into direct conflict with society's belief that the intended recipients pose some form of threat. Further, prisoner's placement within the diverse security levels outlined previously could impact significantly their experience of, and access to, healthcare service provision offered in each case.

The situations of prisoners prior to offence and incarceration are also important considerations in this review, as these impact the health of this population, and its perception of healthcare service requirements in the penal setting. This is an area which has attracted considerable academic interest. Commonly, the literature features the chaotic lifestyle of many people leading up to their

imprisonment, creating a situation in which accessing healthcare and other professional support becomes difficult (Condon *et al.*, 2008). Accounts of poor life experiences are prevalent in the literature. Amongst these works, a number have been included here as valuable in highlighting myriad variety of health-related issues, such as: physical and sexual abuse (Moran and Peterman, 1989), homelessness, mental illness (Hayward *et al.*, 2008), residence in children's homes or care setting (HM Inspectorate of Prisons Youth Justice Board (2009), poverty (Braveman and Gruskin, 2003), learning disability (Bradley, 2009), substance misuse (Fazel *et al.*, 2005), lack of education and school exclusion (Prison Reform Trust, 2003; School Exclusion Unit, 2002), and risky behaviour (Stewart, 2007).

Taken collectively, this material would suggest that the pre-existing levels of chronic ill health and social disadvantage prevalent in this population would demonstrate that equitable healthcare provision is unlikely to mean equitable health outcome. Moreover, social justice, as an essential factor, or enabler, of equity in health assumes particular importance in these considerations.

Particularly relevant to this thesis, the WHO highlighted inequity for different groups in society (Whitehead, 2000, p. 5). Here, the author posed the question: "which health differences are inevitable – unavoidable – and which are unnecessary and unfair?" In an extensive analysis of the international literature, seven main determinants of health differentials were identified (Whitehead, 2000, p. 5):

1. "Natural, biological variation,
2. Health-damaging behaviour if freely chosen, such as participation in certain sports and pastimes,
3. The transient health advantage of one group over another when that group is first to adopt a health-promoting behaviour (as long as other groups have the means to catch up fairly soon),
4. Health-damaging behaviour where the degree of choice of lifestyle is severely restricted,
5. Exposure to unhealthy, stressful living and working conditions,
6. Inadequate access to essential health and other public services,

7. Natural selection or health-related social mobility involving the tendency for sick people to move down the social scale”.

Building on the body of literature presented, the author argued that health differences determined by factors 1, 2, and 3 above would not normally be identified as inequities in health.

Represented within the broader literature showed thus far, this thesis would further suggest that prisoners are disproportionately featured in categories 4, 5, 6 and 7, whilst inequity in their underlying health status, arising from social injustice, is likely to be prevalent.

To summarise this literature review to this point, prisoners enter prison establishments often with multiple physical (and mental) health needs which the NHS is expected to address. However, the penal setting can be problematic for prisoners' personal maintenance of health alongside issues associated with the delivery of healthcare in these establishments. When considered as a body of knowledge from this specific time period, academic work would suggest that, despite its critics, imprisoned patients could, and hopefully would, benefit to some degree from the effective implementation of the equitable healthcare principle in prisons via the Public Health framework.

Whether these endeavours can be successful in a secure prison environment will now be considered, and both facilitators and barriers are debated in order to produce a critical review. The following section addresses the nature of health promotion, specifically in relation to the prison context.

2.5 Health Promotion

The Ottawa Charter for Health Promotion highlights five priority areas for health promotion (as cited in Department of Health, 2002a). These are:

1. “Build healthy public policy,
2. Create supportive environments for health,
3. Strengthen community action for health,

4. Develop personal skills,
5. Re-orient health services”.

The literature related to these areas is extensive, and has been thematically clustered for the purpose of this literature review.

2.5.1 Build healthy public policy

The previous chapter established that, starting with the *NHS Plan* (Department of Health, 2000a), building a healthy public policy was a key objective of the Government’s ten-year health reform programme. This, alongside the specific prison policy and regulation presented, created a clear framework within which the delivery of equitable healthcare to English prisoners should have been achieved. As a central tenant of the new system, consumer choice would drive NHS service quality and performance under the guise of patient choice (Department of Health, 2004). Those organisations attracting the largest number of patients would be rewarded financially for treating them. In a national survey conducted in 2005, however, the Kings Fund found that only 45% of patients could remember being offered a choice of hospital since the policy had been introduced. The policy’s effectiveness must, therefore, be questioned.

Public Health Policy, in tandem with unprecedented financial investment in front-line services, was intended to deliver real health benefit for the most vulnerable patients in England (Department of Health, 2000a; Department of Health, 2004). The NHS Plan’s approach to Public Health was not, however, without criticism. Hunter (2003, p. 64) argued that only “a slim chapter buried deep in the Plan was devoted to improving Public Health and reducing health inequalities”.

Further, the literature shows that this period of Public Health Policy development was coupled with a period of micro-management which conflicted directly with the proposed localism agenda (Paton, 2006). It is posited here that substantiation of this can be found in the introduction of a wealth of NSFs, HImPs, JSNAGs and other Frameworks and monitoring tools. Here, these key documents were simultaneously implemented to identify and capture positive

health outcomes, and to measure provider progress against key national targets.

The previous chapter demonstrated that frameworks and tools alone will not create health benefit. Policy implementation was found to be of equal importance (Easton, 1953). Further, it is argued by a number of influential academic studies that plans to reduce inequity in health cannot be simply imposed on people (World Health Organisation, 1986). Collectively, these works argue that people must feel that solutions are based on their own needs, and have not simply been imposed by external bodies.

This aspect of the Government's strategy for health improvement must also be questioned. Here, despite the undoubted focus evident in the literature, progress against targets was found to be slow, highlighting a lack of effectiveness in the implementation of this agenda (Department of Health, 2008b).

2.5.2 Create Supportive Environments

Taken here, a supportive environment could mean two things. Firstly, it could refer to the confused policy environment at the point of transfer described in Section 2.5.1. Secondly, supportive environments could also refer to the physical environment in which prison health care is delivered, which has long been considered to cause harm. As early as 1958, Sykes established that to deprive someone of their liberty can be every bit as detrimental as the physical punishment of previous years. More recently, Massoglia (2008) identified prison as the primary stressor in recent times.

The majority of penal investigation on this subject of prison culture has been produced predominantly in the United States of America, especially prison culture oriented research. This academic focus is understandable when one considers that whilst consisting of only 5% of the world's population, America incarcerates almost 25% of the total number of imprisoned people. Conducting meta-analysis on American prison studies published between the years of 1977-2005, Spelman (2009) warned that the American example should be held up as an international warning about the effects of poor penal policy to the rest of the world. This could be a timely message for England and

Wales which currently claims the highest rate of imprisonment in the European Union (EU).

In an English study, Condon *et al.*, (2008) examined literature from 1995 to 2007, using standard review techniques to explore the nature of primary care practice in prison. The study concluded that prison significantly mitigated any positive effect of treatment. The penal setting is not an easy place in which to provide healthcare that proves effective. The underlying impact on mental health and wellbeing is a constant feature in the literature. These studies, however, differ considerably.

One useful study for inclusion here relates to the emotional distress a person suffers within the prison setting, especially those subject to a *true life-sentence*, or life without parole. Long considered to be an American issue, recent changes in British penal policy have led to a situation in which one in seven people imprisoned is now serving an indeterminate or life-sentence (HM Chief Inspectorate of Prisons, 2009). This figure is higher than the combined life imprisoned total for the entire Western world, yet there is limited academic data about the impact of indeterminate sentences on prisoners in England to date (Nagel, 1984).

Additional aspects relevant to this sub-theme can be drawn from American studies. For example, in the United States, imprisonment for life has been described as “the other death penalty”, (Johnson and McGunigall-Smith, 2008, p. 328). Here, these authors uniquely highlighted the increasing number of life-sentence prisoners that have, instead, chosen to exchange this punishment for the death penalty in America. Johnson and McGunigall-Smith (2008) argue prisoners made this choice in order to escape the lifelong pain and hopelessness of their circumstances and the nature of long-term imprisonment. A limited sample of seven death-row participants consented to be interviewed, suggesting that further research is required before any firm conclusions can be drawn and disseminated via this work. Although the death penalty does not exist in Britain, the emotional distress of life without parole for this growing cohort is also worthy of consideration.

Taken together, these studies could be argued to indicate that the provision of a supportive environment in which equitable healthcare can be provided is difficult to achieve. An affective and forceful combination of security constraints, disease, substance misuse and addiction, physical and mental frailty, and “sub populations with special needs” (Cropsey *et al.*, 2007, p. 80) exist across the prisoner population. These underlying issues are likely to be further complicated by the security status of individual prisoners, as posited previously.

To summarise, these factors present both commissioners and providers of healthcare in prisons with considerable challenges (Fazel *et al.*, 2001). Moreover, it could also be argued that, despite the assertions of some (Department of Health, 2002a; Edge, 2006; Macdonald, 2006; Massoglia, 2008), imprisonment in this secure environment, for the majority of these forcefully contained persons, cannot be considered of benefit to health and/or health giving. Notably, references included above do not argue the penal setting is health promotion *per se*. Rather, this literature highlights the potential of useful health provision in the prison context.

Despite these difficulties associated with the provision of healthcare across the prison service, there is limited support to suggest that health commissioners have addressed this need to provide a more supportive environment for this prisoner sub-population of UK society. To exemplify this gap between research and practice, Flynn (1992), presented the plight of incarcerated older people, yet the situation of geriatric prisoners remains a contemporary concern. More recently, Docherty (2009) and Potter *et al.* (2007) focused attention on this issue. This has led to the commissioning of a limited number of specific geriatric units. These units, it is argued contribute to the provision of specialised care and treatment.

Still, no mechanism currently exists to refer older prisoners directly from court in England if they exhibit frailty or behaviours which indicate they require this care. Instead, individuals must negotiate the prison system until they reach these specific units, if they are fortunate enough to do so. At present, there is no national approach to the development or utilisation of these geriatric units across the Criminal Justice System. Certainly, the lack of patient choice,

evident here, contradicts the Government's stated objectives to reduce health inequality (Department of Health, 1998).

In relation to the notion of equity that underpins this thesis, these issues are pertinent. It could be argued that this situation is inequitable when compared to the experience of older people, and their health and social care in the wider community. This is not, however, straightforward as citizens in the external population also experience widely different services which impacts directly on their life expectancy, health and wellbeing. In an international comparison of national life table data from the Human Mortality Database, Vaupel *et al.* (2010) found that those countries which were most successful in averting premature deaths also had the lowest male and female life disparity. A focus on Health Promotion is, therefore, consistent with this argument.

The work of Health economists is also worthy of brief consideration here. It has been argued that the current "fixation with equity issues", and the improvement of health for all, has pervaded at the expense of the efficiency agenda (Bosanquet, 2001, p. 228). Here, intergenerational equity described as the principle of a *fair innings* (Williams, 1997) is of particular relevance to this thesis. In a general sense, it is posited that fairness, or justice in relation to intergenerational equity, leads to the subservience of older peoples' healthcare needs to those of other groups when resources become scarce. Thus, older people are prevented from accessing healthcare provision, as their large numbers and extensive ill health would result in scarce provision for future generations. Bosanquet (2001) argues that this has become too much of focus for health economists and, in so doing detracted from the need to look instead at cost-efficient preventative services for all. By inappropriately concentrating on the ethical dilemmas of health delivery, the author argued, provider organisations have been excused the need to drive down cost and increase the quality of their offer.

2.5.3 Strengthen Community Action for Health

The health of prisoners has been found to be inequitable and, for example, it is estimated that the prison population ages 10 years prematurely (Oliviere *et al.*, 2004). Many will die young from coronary heart disease and other life limiting conditions as a result of their health-damaging life journey (Wentforth-James,

2009). If it is to be successful, community intervention and prevention for families and individuals at risk is required long before they are imprisoned. For those damaged before birth through maternal misuse of drugs and alcohol, early intervention may still be too late (Gardner, 1992). This is relevant, and falls outside of the WHO's (Whitehead, 2000) seven health categories mentioned earlier. Here, the health inequity suffered by these children is inflicted through the health-damaging behaviour of another, suggests that this framework requires expansion.

The affect of traumatic life experience on the psyche is increasingly attracting academic interest. This, too, could pose a challenge to this component of the Public Health framework. Childhood sexual abuse, most of which takes place in the community, is of particular concern. Glaser (2000) demonstrated that early trauma has the capacity to both affect and effect the neurological formation of the brain. As a result, this profoundly impacts the way people experience life thereafter, as the consequences of this early trauma had become hardwired into the brain's very structure.

Of relevance to imprisoned patients, Easteal (2001, p. 87) established that childhood abuse led to an inability to "trust figures of authority". This finding was supported by Howerton *et al.*, (2007). Here, there is some danger that the provision of community healthcare support, equitable or otherwise, may, as a result, be repelled by its intended recipient. Although Easteal's (2001) research was concerned with female Australian offenders, some useful parallels can be drawn with the experience of women in English prisons. The author argued that what was described in popular psychology, as the *shame core* may lead female prisoners into addictive behaviour or relationships which are characterised by abuse.

Psychological damage has also been found to be caused to prisoners by familial separation. This has been predominantly found to be the case for women and mothers. In a comparative study, examining the gendered effects of social support on inmate's behaviour, Jiang and Winfree Jr., (2006) concluded that women had greater social support needs whilst incarcerated. There are, indeed, different groups of prisoners in the UK's prison system with divergent health and social care needs. Applying a multilevel experimental

analysis on a national sample of male and female prisoners, the study conducted by Jiang and Winfree Jr., (2006) demonstrates that women receiving pro-social support participated more readily in prison support programmes. This, in turn, became a virtuous cycle of additional support and protection from the occasionally harsh realities of prison life. Furthermore, for some women, this has to be dealt with during pregnancy.

To summarise, the psychological impact of imprisonment at this (health-related) time is considered to be generally negative. Edge (2006), for example, found two-thirds of pregnant women, and those in the prenatal period, were depressed.

Support for the importance of the continued role of mother was also identified by Kolman (1983), who argued that imprisoned women initiated verbal interaction with their children. Coercive control, followed by positive support, were the most frequent types of power and support exhibited by others as shown in Kolman's (1983) work. Moreover, Dodge and Pogrebin (2001) examined family separation and community isolation through in-depth interviews with 54 former inmates. The authors argued that support from relatives enhanced the women's emotional survival in the prison context. Significantly, the study identified that social stigma and shame created serious barriers to re-integration with external society. This stigma may pose particular challenges to the strengthening of community support initiatives and achieving equity in health outcomes post-sentence.

By contrast, Green *et al.* (2005) argued that the history of trauma and victimisation which many imprisoned women had experienced pre-imprisonment, often left them unlikely to consider their children as anything other than objects of adult gratification.

2.5.4 Develop Personal Skills

The development of personal skills to positively affect one's own health is dependent on the cognitive ability to assimilate knowledge and techniques. Yet notably, the imprisonment of the vulnerable is a powerful theme in the literature today and can alter negatively the utilisation/learning of these personal skills (Bradley, 2009; Docherty, 2009; Hayward *et al.*, 2008; HM

Inspectorate of Prisons and Youth Justice Board, 2009; Home Office, 2007; Yorston, 2004). Although these studies differ considerably in approach, if considered together, they construct a body of knowledge to suggest that many of the persons housed in English prisons are ill equipped to cope personally with the penal regime, and should, perhaps, be cared for in therapeutic-orientated environments.

This vulnerable cohort may, therefore, find this aspect of the Public Health Agenda challenging, suggesting that the development of personal skills must be facilitated on an individual basis according to one's ability. Such an approach is likely to be both time consuming and costly, were it to be implemented. Individualisation in the prison system is challenging as, overall, this service operates a system that manages prisoners as social groups or communities.

Further, the inequitable experience of the socially disadvantaged, it has been argued, requires the pursuit and elimination of health disparities and inequalities where they are found to exist (Braveman, 2006). The clustering of specific patient cohorts, such as those above, is unlikely to produce the granularity required to effect this transformation. This, in turn, highlights the extreme challenge of achieving equity for the most vulnerable within the penal environment.

For those prisoners with learning disabilities, the prison setting is considered to be specifically problematic (Bradley, 2009). In a six month (later extended to 12 months) national independent review, Bradley (2009) explored some of the complex issues and barriers to court liaison and diversion schemes for this community, and those affected by mental health issues. He found considerable confusion around the terminology employed and difference of opinion regarding when diversion should take place. It was also acknowledged that diversion increased the risk of inappropriate or dangerous behaviour at community level, bringing it into direct conflict with the NHS *Zero Tolerance* agenda.

To conclude this sub-section, a number of positive recent prisoner peer support initiatives are proving beneficial. These include listeners, befrienders,

and health advisors. Moreover, these schemes are also providing useful and worthy skills and experience, to use in society post release from the prison establishment, and may thus develop future employment opportunities. As a result, there is some possibility that an initiative in prison may help to reduce social injustice and the economic disadvantage disproportionately affecting this population. What is more, this may lead to improved health outcomes in the long-term post-release.

2.5.5 Re-orientation of Health Services

The re-orientation of health services in the prison environment is also fraught with numerous complex challenges, and prisoners can reject much of the therapeutic support offered to them. This is chiefly the case for those who experience mental ill health in the penal setting (Gray *et al.*, 2008). The authors examined the nature and clinical correlates of adherence to prescribed antipsychotic medication in a regression model with 44 prisoner participants. To summarise, the evidence indicated that the treatment options available to mentally ill prisoners were constrained by the prison setting. Of relevance here, the associated restrictions placed on movement or involvement in treatment decisions invoked feelings of coercion amongst patients. Refusing to comply with the therapeutic regime, it was argued, could render the individual at risk to both themselves and others.

This supports the previous argument that patients are likely to reject plans to improve their health if they consider that these have been imposed on them externally (World Health Organisation, 1986). Moreover, it could be offered that this underlying resistance creates a considerable challenge to service planning and design for imprisoned patients. Further, service re-orientation may unintentionally create inequity amongst specific prisoner cohorts, such as the one described above, who will not be in a position to benefit fully from these initiatives due to their underlying illness or condition.

2.6 Health Education

Health education represents the second part of the theoretical framework for this chapter. Elements considered important for the effective provision and delivery of Public Health (Department of Health, 2002a) include: interventions and programmes for people to learn about health, opportunities to undertake voluntary changes in behaviour, provision of information, development of skills and building self-esteem. These four facets of health education, as conceptualised by the DH, are now reviewed.

2.6.1 Interventions and Programmes for People to Learn About Health

Health-related interventions that focus on the positive development of individual social actors' / patients' health-oriented knowledge are complex, and the effectiveness of these programmes is often questioned. Success is arguably dependent on a person's willingness and ability to further learn about their health, and the nature of good health practices more generally. For example, it has been established that prisoners can be deeply distrustful of professional intervention and figures of authority; the words "don't talk, don't trust and don't feel" it has been posited, exemplify the prison code and culture by which many prisoners live their lives (Easteal, 2001, p. 87). Easteal's (2001) data revealed that, despite the implementation of positive steps towards better health knowledge possession of the prisoner population, female prisoners' dysfunctional attitudes in prison remained unchanged. The worth and success of interventions and programmes for people to learn about health in a prison environment may, as a result, be challenged. There is certainly room for development in this field of prison healthcare.

Furthermore, the ways in which female prisoners, in particular, are able to resist attempts at health-related assistance in the penal setting has also been discussed. Craig (2009) analysed the emergence of mother and child health-related programmes, dating back to Elizabeth Fry's work mentioned previously. The author cautioned that historic accounts of intervention should be examined for lessons learnt with care, in order to elicit women's abilities, desires, and options to resist health programmes. Their profound mistrust of professional intervention, according to Craig (2009), means that prisoners need to find other means of coping with the psychological damage inflicted,

both pre-and post-imprisonment. The nature of trust in the prison setting, in relation to healthcare and prison staff, can be problematic for the prisoner population.

Despite the attendant challenges, van de Bergh *et al.* (2009) argued that the minority status of women in prisons has led to an historic neglect of their health needs. This “inexcusable gender insensitivity”, the authors said, dominates the European criminal justice system and fails to meet the standards of human rights demanded by international law (van de Bergh *et al.*, 2009, p. 406). Calling for a real commitment to the principles of social justice and equity, the authors highlighted the need for gender-sensitivity training for policy making staff involved in service provision to this vulnerable population, if this service were to be successful. There is clear accordance here with the WHO’s view on these matters outlined previously (Whitehead, 2000).

Therefore, to conclude this section, programmes of health knowledge-orientated intervention in the penal environment need to be able to identify and work effectively alongside these underlying forms of, sometimes invisible and covert resistance, if they are to be successful.

2.6.2 Opportunities to Undertake Voluntary Changes in Behaviour

Prisoner behaviour is one area of study which has attracted academic interest over several decades. However, whether this social grouping is amenable to change on a voluntary basis remains difficult to establish.

The prisoner population literature, to date, does not provide a definite approach to this facet of health education and its associated processes. Notwithstanding this relative absence, several pieces of work are relevant for review.

For example, one influential early study conducted by Glaser (1967) suggested that prisoners’ behaviour is shaped through the process of stimulus and response. The stimulus and response theory within the behaviourist school of psychology offers a useful model against which this thesis considers some of the diverse behavioural patterns prisoners’ exhibit. It may also help to

establish whether prisoners are capable of embracing the opportunity to make voluntary changes in their health-orientated behaviour, as required.

Behavioural responses to life experiences are unique, both to the individual, and to the situation. Learnt behaviour in childhood considered to be a good predictor of future adult behaviour, enshrined in the early Jesuit motto: *give me a child until he is seven and I will give you the man*. If this model of human socialisation is accepted, people arriving at prison to commence their sentence appear with a complex set of behavioural patterns already firmly established. Consequently, these may impact their responses to life inside prison during their sentence. It is likely they will also affect their abilities to benefit from health services provided.

People enter prison, therefore, with pre-established beliefs, attitudes and behaviours (Huggins *et al.*, 2006; Morello, 1961; Wolff and Shi, 2009), and are confronted with a repetitive and strict prison regime. This operates to a stringent bureaucratic code with a multitude of rules and regulations. In terms of the purpose of custody in the prison establishment, the Prison Service must ensure security and protect the public from (potential) harm. Prisoners also meet the culture and behaviour of their wing-based peers, with which they must adapt and respond (Rosen, 1990). Those who do not possess the knowledge and ability to do so are at a distinct disadvantage in the prisoner social system (Bradley, 2009; Docherty, 2009; Yorston and Taylor, 2009).

For women prisoners (Home Office, 2007; Jiang and Winfree Jr., 2006) and those prisoners with a learning disability (Bradley, 2009), this has been found to be specifically challenging, leaving them vulnerable to reproach from their prisoner peers. For other authors, for example Claes *et al.* (2004), prison behaviour has been found to be highly ideographic in nature as prisoners construct their own version of reality. However, in contrast, those who are perceived as strong prisoners find infinite possibilities “for personal victimisation” (Bowker, 1980, p. 19). To conclude this sub-section, health-based behavioural modification programmes must also be appropriate to the complexities of the prison environment and the population it contains, if health improvement is to be attained.

2.6.3 Provision of Information

De Viggiani (2007) documented a disproportionate number of prisoners who have previously resided on the margins of society pre-sentence. Within this definition, the author argued, fall people who do not have the education, ability, resources, power, autonomy or support to participate in the choices the rest of society may take for granted. Social exclusion issues often persist for this social group before committing offences, and are pertinent to the argument that social injustice drives health inequity as developed in this thesis. Poverty and disadvantage further impact early damage and, in turn, may lead to constant uprooting, lack of secure housing and homelessness (Braveman and Gruskin, 2003). Therefore, the ability to secure oneself in a community and access its information services and other resources will be poor, further exemplifying the nature of the lives of many prisoners pre-institutionalisation.

To focus on the provision of information, specifically, the Inverse Care Law (Tudor Hart, 1971) idea demonstrates prisoner access to computer-based IT programmes which are otherwise available to the external community, to be non-existent. Returning to pre-offence community-based living, the education that is considered a right for UK citizens may also be out of reach for these members of society, as poor school attendance may lead to education exclusion at a young age (Prison Reform Trust, 2003). Reportedly, a significant number of all prisoners can only read at the expected level of an 11 year old child (Level 1 in the National Curriculum) (Social Exclusion Unit, 2002). For numeracy, this figure rises to two-thirds, and for writing four-fifths. It is improbable that those with poor education will be able to access easily Public Health related information in the community. This population is, therefore, unlikely to have been affected by the Public Health Agenda, since much of the information published is online or included in written reports and papers.

Notably, prisoner deaths occur as a result of the very conditions the Public Health Agenda was intended to correct (Department of Health, 2004). Therefore, establishing effective mechanisms through which to inform this population about the improving health agenda may contribute appreciably to reducing prisoners' level of disease.

2.6.4 Development of Skills and Building Self Esteem

Investment in programmes to boost work-related and wider social skills is already a long-standing priority for the Prison Service. The low underlying levels of self esteem present in English prisons, however, presents a challenge, with prisoners often adopting religious belief as a preferable form of coping strategy (Thomas and Zaitzow, 2006). It is possible to argue, however, that this practice is not necessarily a negative strategy, and that religion and healthy living may be useful in tandem.

Regarding additional coping strategies enacted by prisoners, self-harm and suicide (viewed by some prison staff as manipulative and/or a coping strategy), are also widely recognised (de Hart *et al.*, 2009). Self-harm is broadly accepted to be a means by which prisoners consider themselves to relieve the anxiety of incarceration and other stressors with suicide being the most severe form of self-harm. In a quantitative study which assessed perceptions of mental health staff regarding aetiology, maturation, and manifestations of self injury, de Hart's study was unusual as it focused on the prison officer perceptions of self injury.

Considered prevalent amongst prisoners, self-harm rates are stated to have been the subject of considerable academic interest. In a detailed analysis of prison suicide and self-injury data, Brooker *et al.* (2010) found that suicide in English prisons had reduced following a number of prison-based initiatives. In 2008, however, the authors reported an increase in self-harm rates which rose to 259 per 100 prisoners. Concluding the study, Brooker *et al.*, (2010, p. 17) argued that "mental health In-reach team members were trying to intervene with the impact of prisoners abusive histories badly equipped with the skills and resources to work constructively with such issues". These findings are unfortunate and suggest that the Darzi's hopes for highly trained staff at the heart of improved patient care (Department of Health, 2008) have thus far failed to be delivered.

This population is consistently, therefore, identified within the literature to present a significant challenge to those attempting to instil and build new skills and self esteem.

2.7 Disease Prevention

Disease prevention represents the third strand of the Public Health Agenda. Here too, the literature has been thematically clustered under the relevant sub-sections.

2.7.1 Measures Not Only to Prevent the Occurrence of Disease (such as risk factor reduction...)

The health-based risk factors associated with imprisonment are somewhat different to those experienced in the external community, and are particularly challenging to a disease-prevention agenda presented here. Little support has been found concerning the ability of large prisons in particular, to address the multifaceted health needs of this population. Important when considering prisoner health, Cropsey *et al.* (2007) argued that large prisons resulted in an ad hoc medical and social service delivery system. Therefore, it is arguably possible to infer that such institutions cannot adequately provide for the multifarious and complex ill health of the offender population with its increasingly ageing demographic and geriatric health needs (Yorston, 2004). Cropsey *et al.* (2007) further suggested that specialised provision in smaller prison units could contribute towards countering the current inequitable provision in prison healthcare.

Prison overcrowding in England is a further area of risk identified in the literature, presenting noteworthy challenge to the prevention, and spread where existent, of disease (Collins, 2010). Poor outcomes associated with prison overcrowding were recently reported in studies which argued against the proposed Supermax Prisons in England (Prison Reform Trust, 2008b). Citing the American example, Mears (2008) argued that Supermax Prisons diverted resources away from strategies which were known to have a positive result. Although the impact of overcrowding is an important area for research and alteration, studies have been criticised for methodological inconsistencies, and the lack of a unified approach. The production of inconsistent findings was thought by Steiner and Woolredge (2009) to be of particular concern.

Within the wider prison population, older prisoners are also considered to be principally at risk (Wentforth-James, 2009), and it is argued that resources

need to be particularly spent on this group (Yorston and Taylor, 2009). Additionally, in relation to further prison social culture issues, a fear of mixing with others has been identified as leading to reluctance to exercise (Docherty, 2009). The negative impact on the health of these individuals arising from this would be considered to be both unacceptable and avoidable within the WHO's (Whitehead, 2000) definition of inequity outlined previously.

What is more, this situation could also be described as both unjust and unfair, as it leads to health inequity which the prisoner is unable to avoid without effective intervention of others. Furthermore, the high prevalence of sexual offence amongst this incarcerated elderly social group has been found to lead to an assumption that all older prisoners are similarly guilty. Hence, they are often subject to violence, thus inflicting damage to older prisoners' health and wellbeing (Tewksbury, 1989). This situation is further complicated when medication is occasionally stolen in the penal environment (Docherty, 2009).

Another risk to prisoner health is bullying behaviour, which is widely reported in the literature (Ireland *et al.*, 2009; Wolff and Shi, 2009). Moreover, others prisoners can fear sexual or physical attack (Tewksbury and West, 2000). In an early study, O'Donnell and Edgar (1999) surveyed 1,182 inmates, and examined their exposure to fear in a prison environment, finding that most inmates had witnessed an assault in the previous month. Despite this, most reported feeling safe from attack. Clear prison rules emerged from participant accounts regarding those whom they considered *deserved* to be attacked. About 72% agreed, for example, that sex offenders deserved to be treated that way, and that it was legitimate to bully or attack *grass*es. Three quarters of participants in the study felt that other prisoners would intervene and protect them personally from attack.

Prison guard attitude was also found to be fundamental to whether bullying was permitted in individual prisons (Wolff and Shi, 2009), suggesting an important institutional element to this behaviour. A large participant population consisting of 7,000 men and 560 women took part, drawn from 12 adult male, and one female prison. The study identified that approximately 51 murders took place in American jails annually, highlighting the difficulty Prison Authorities face when trying to protect the health of prisoners.

Although the Public Health Agenda presents a useful framework within which to review the prisoner health literature, it is here posited that it is essential that the key health improvement priorities mentioned in Chapter One are also considered under the disease prevention heading. A number of specific priorities for health improvement outlined in *Choosing Health: Making Healthy Choices Easier*, (Department of Health, 2004) are salient. Five of these include: reducing smoking rates, reducing obesity and improving diet and nutrition, increasing exercise, encouraging and supporting sensible drinking, improving sexual health. These relevant issues will be discussed in the sections that follow.

1. Reducing smoking rates

Smoking is an example of health-damaging behaviour which is freely chosen (Doll *et al.*, 1994; Whitehead, 2000). Despite a very low prisoner income, only £2.50 per week for some, smoking and its associated disease are widespread in English prisons. This study has identified that there is a paucity of national data available identifying the numerical prevalence of smoking in English prisons. It is estimated, however, that half of all smokers will die of a smoking-related disease, such as chronic obstructive pulmonary disease, heart disease, lung, and other cancers, and stroke (Doll *et al.*, 1994). Smoking is, therefore, likely to be widespread.

In a cross sectional study of 1,275 inmates, randomly selected from an American State prison population, Crospey *et al.* (2006) examined the relationship between tobacco use and oral health of inmates. The authors argued that smoking cessation targets could also be assisted if prison dentists took a proactive role in smoking cessation advice. The lack of effective implementation, however, arguably represents a lost opportunity for disease prevention.

2. Reducing obesity and improving diet and nutrition

Despite healthy eating options available on the menu, prisoners may enter prison with unhealthy consumption habits already established and continue in this practice. Therefore, the mere provision of defined healthy food options by the Prison Service is insufficient. Poverty, coupled with homelessness, poor housing, and chaotic lifestyles pre-offence and imprisonment, often render it

difficult to achieve a healthy diet and the adequate levels of nutrition necessary to prevent disease for this social group in England.

This literature review has identified that much of the damage will have already been inflicted on the health and wellbeing of individuals prior to incarceration arising from these social injustices. Literature could not be identified which indicated that a brief period of access to healthy food had a positive long-term impact on health.

3. Increasing exercise

As confined spaces, facilities for exercise, both within the prison and outside in the exercise yard, are limited and mainly so in older prison establishments. This situation is further challenged by acute pressure on staff time to oversee exercise programmes. This resource-dependent position results in many prisoners being locked in their cells for an excessive number of hours per day.

For the disabled and sick, the design of older prison estates may further reduce a prisoner's ability to participate. Lack of ramped access and other physical adaptations could also create physical barriers which are difficult to overcome for those prisoners with disabilities. These important areas have received little academic interest and, as a result, it is difficult to reach any firm conclusions regarding this area of policy success and/or failure. Furthermore, the detrimental impact on prisoners' health arising from this lack of exercise contradicts the WHO's (1986) demand that nobody would be disadvantaged from achieving their full health potential.

4. Encouraging and supporting sensible drinking

Similar to smoking and nutrition, here too, prisoners have life-long established patterns of alcohol misuse prior to imprisonment (Joint Prison Service and National Health Service Executive Working Group, 1999). Narcotic and intoxicating substances are widely used and misused in prisons. Estimates of the level of addiction within English prisons, however, vary greatly. Broadly speaking, it is accepted that prisons house a disproportionate number of people addicted to drugs, alcohol, or who are co-dependent (Easteal, 2001; Joint Prison Service and National Health Service Executive Working Group, 1999; Keil and Samele, 2009; Ramsbotham, 1996).

The psychological literature about addiction offers viable explanations for this cluster into two main suppositions: firstly, that people misuse drugs and alcohol because they are either driven by a need for stimulation, or in an attempt to reduce anxiety (Hussein Rassool, 2006; Hussein Rassool, 2009); secondly, that they suffer a disease which is rooted within the genetic or biological blueprint for an individual (Jellinek, 1960; Valliant, 1983). Here, this “natural, biological variation” (Whitehead, 2000, p. 5) is not identified to be generally classified as inequitable in the health literature.

The work of Jellinek (1960), and later Valliant (1983) firmly places the misuse of drugs and alcohol in the healthcare domain, which perhaps suggests the need for a treatment response to ameliorate the damage to individual health. Health education and information alongside health promotion programmes may offer relevant opportunities to address this reason for health-related behaviour.

It has been argued that the pharmacological evidence base is severely lacking in England, due to the limited availability of clinical data in prisons (Roberts *et al.*, 2007). Fazel *et al.* (2005) found that substance misuse in the prison population is highly variable ranging from 18 to 30% for males and 10 to 24% in female prisons. More recently, HMCIP for England and Wales (2009) established the problem of alcohol addiction had risen between three and four-fold in the space of only two to three years, and demanded effective screening for substance abuse on reception.

In an isolated study, however, Plugge *et al.* (2006) found confirmation that for some prisoners, alcohol consumption actually decreased during imprisonment. However, a lack of programmes to support those addicted to alcohol is more widely criticised (HM Chief Inspectorate of Prisons, 2009), whilst many prisoners continue to use alcohol to the detriment of their health during their sentence casting some doubt on Plugge *et al.*'s (2006) findings.

5. Improving sexual health

The chaotic lifestyle of this population is well documented, and presents a challenge to the medical interventions target also. The prevalence of sexual abuse in particular, it is argued, is underestimated in the literature (Tewksbury

and West, 2000). Coupled with risky behaviour of a sexual nature, rape and coerced sexual lifestyles, the prison population has an extremely high prevalence of sexually transmitted infections (STIs), and blood-borne viruses (Abiona *et al.*, 2010; Stewart, 2007). High rates of HIV, hepatitis B and C are of particular concern in male prisons (Stewart, 2007).

Literature presents a persuasive argument that sexually transmitted disease is spread through both consensual, and non-consensual sexual activity. Stewart (2007) argued that wider availability of condoms could contribute towards improving this situation. Academics working on risk-taking behaviours indicate that this is dubious, and that Stewart's assertions are somewhat naive. Voight *et al.* (2009) using Carver and White's (1994) BIS/BAS scales found, for example, that some participants engaged in risk-taking behaviour almost inherently. Paradoxically, imprisonment itself may lead to risk-taking behaviour, rather than factors previously present in the external community (Krebs, 2002; Voight *et al.*, 2009). This indicates that prison may facilitate the opposite of improving sexual health in some cases.

A number of more recent studies cluster around explaining risk-taking behaviour and concern regarding the transmission of HIV amongst the prison population. Krebs (2002) explored high risk HIV transmission behaviour in the prison sub-culture and identified that, despite displaying none of these behaviours outside, some prisoners indulge in such transmission activities when faced with the deprivations associated with imprisonment. Out of the 121 participants in the study, 44% reported to have had sex inside prison, only 30% of them had had sexual contact with someone of the same sex before coming into prison, 58% reported having had oral sex, and 16% reported having been raped inside prison. This study highlighted an aspect of offender behaviour which can, for many, lead to the transmission of sexual and other diseases.

This area of study is further complicated by Collica's (2002) explanation of levels of knowledge and risk perceptions about HIV/AIDs amongst female prisoners in New York State. The study found that, despite calls for better education in prison, high levels of knowledge did not significantly affect prisoners' behaviour, or create accurate risk perceptions. Women participants

reported that men possessed all the power in a sexual relationship, and 37% said they would not make their partner wear a condom or dental dam if he was uncomfortable to do so. Clearly, these women were at risk of disease or infection and raise important issues of the inequitable status of women beyond their health experience.

Unlike consensual behaviour outlined here, sexual attack is another aspect of prisoner behaviour which may damage health (with both psychological and physical potential ramifications). It is also another area over which individuals have little control. It is difficult to establish the true prevalence of sexual assault and rape in the literature, as researchers are divided on this point. The primary barrier is the stigma attached to self reports and this, it has been argued, makes it likely that accurate data does not exist. Tewksbury and West (2000), for example, asserted that fear of sexual assault amongst male prisoners may be of greater impact and more common than the actual incidence rates of sexual assault. These findings supported Eigenberg's (1989) earlier work which highlighted the paucity of data on this subject, and argued that current data on male rape was underestimated. The author also found that officers chose to ignore complaints from men they did not consider *typical* rape victims, indicating that Tewksbury and West's (2000) findings should be treated with caution.

The literature would suggest that facilities in prison to treat these conditions are essential, if the damage to prisoners' health is going to be prevented. For some, however, infection of blood-borne viruses, such as HIV is incurable, but they can be controlled, to an extent, if detected early enough and given an appropriate therapeutic regime. The sexual abuse and exploitation of some will continue during their prison sentence unless challenged at an institutional level.

2.7.2 Medical intervention

Prisoners are known to have been poor users of health services prior to their incarceration. It is improbable that they will have previously benefitted from vaccination, health screening, dentistry (Harvey *et al.*, 2005; Tickle *et al.*, 2007), and other useful Public Health programmes. This indicates that advances in medical intervention, discussed in the previous chapter, have

largely bypassed this sick community. No indication exists in the literature to link health outcomes to this system-wide neglect, although it is not likely to be anything other than detrimental.

Effective medical intervention is further prevented by an avoidance and lack of belief that people in authority had their interests at heart (Howerton *et al.*, 2007). The authors identified that negative feelings, expressed most often against health professionals, were that they “just don’t care” (Howerton *et al.*, 2007, p. 3). This study should, however, be treated with caution due to the small sample of participants, namely 35.

2.8 Healthy Settings

2.8.1 Ability to take control over one’s decisions and life circumstances

It is argued that the lack of routine *screening* has lead to a situation in which the needs of vulnerable prisoners with learning disabilities is both unrecognised and unsupported (Great Britain, 2005; Loucks, 2007).

There is also confirmation that prisoners with mental health issues may exhibit unhelpful inappropriate behaviours in relation to prison rules and regimes, and poor problem-solving ability, which has also been associated with distress and suicide ideation amongst young prisoners (Hayward *et al.*, 2008). For another vulnerable cohort, Yorston (2004) identified that there are no satisfactory studies of older people with mental illness who commit offences. Despite this general absence in the literature, the author established that people over 60 years of age commit 11 murders, and over 300 sexual offences, in the UK annually. The author argued that the lack of appropriate facilities leads to many of them being placed in prison healthcare units which are unable to meet their needs. This is particularly the case for Alzheimer’s Disease related aggression amongst prisoners (Yorston, 2004).

The mentally ill, and learning disabled remain inappropriately housed in prison. Despite the publication of the 2001 White Paper *Valuing People*, the *Disability Discrimination Act (1995)*, later substantially amended by the *Disability Discrimination Act (2005)*, 20-30% of offenders have learning

disabilities/difficulties (Loucks, 2007). This, the author suggested made it difficult for them to cope with the criminal justice system and its required regulations and rules. This suggests that this group is not readily able to take control over its decisions and life circumstances, and positively affect its health. Bradley (2009) similarly found that a lack of adequate assessment and identification at an early stage meant that this went largely undetected. In all, Bradley made 82 recommendations. Amongst these were: identifying poor continuity of care, poor information and information sharing, lack of joined-up services for people with dual diagnosis, and departments working in silos at both local and national level.

The fourth major theme within the theoretical framework for this chapter is Healthy Settings. Therefore, the pertinent literature will be critically evaluated now under the relevant Public Health sub-headings outlined at the beginning of this chapter.

2.8.2 Ensuring the Society One Lives in Creates the Conditions that Allow the Attainment of Health by All Its Members

Those subject to incarceration face a period of time detached from community life behind the prison walls, and enter prison-specific societies within prisons where their liberty is deprived. Thus, prisoners are posited to undergo a series of psychological adjustments to the penal setting discussed previously, until they are released back into society (Clemmer, 1958; de Viggiani, 2007; Sykes, 1958). At this point, offenders return to the community, in some sense, carrying the impacts of their prison experiences which are largely regarded as negative (Jiang and Winfree Jr., 2006; Ramsbotham, 1996).

It is essential, in this review, to make reference to the author who first theorised the notion of prisoner socialisation. Clemmer (1940), the pioneer who identified *Prisonisation*, as it became known, remains of significant academic interest today as the issues he debated continue to have salience with the criminal justice system. It is argued that to become *prisonised*, prisoners are socialised, taking on the norms of prison life (de Lisi and Walters, 2009; Gillespie, 2002; Lawson and Ward, 1996; Sykes, 1958). The aforementioned prison interested academics and authors narrate a prison society of both formal and informal rules behind the prison walls, with which

prisoners must adapt, if they are to survive in the penal setting. This has been found to be anything other than an equitable experience. Prisonisation is a complex issue, and the motivation to become *prisonised* is recognised to be a psychological process, driven by explicit and implicit beliefs and assumptions relevant to prison social environments.

Building on Syke's 1958 Deprivations Model, de Viggiani (2007) later argued that a prisoner's ability to survive imprisonment will depend on their capability to withstand the deprivations of that environment. Therefore, prisoners' health is as much influenced by structural determinants of the prison, as it is by the physical and mental health of the individual. De Viggiani (2007, p.115) felt that prisons "epitomise the antithesis of a health setting". A healthy prison was, therefore, "an oxymoron". His study is one of a limited number of firsthand research studies with imprisoned English patients and is, as such, a limited, but valuable source of data relating to this study's target population. Further, this work highlights the apparent illogicality of the ability to achieve equitable healthcare provision within a highly variable and inequitable landscape when compared to patient experience externally. Caution is advisable before applying these experiences to other prisoner groups such as women, and young people, as this work only involved male adults. Moreover, interviews with participants took place between 1998 and 2001, which pre-dated the transfer of prison healthcare to NHS responsibility. Therefore, the issues identified by de Viggiani (2007) could now be somewhat out of date.

The literature also has examples of effective psychological adaptation to imprisonment through the formation of prison social gangs. The field of social psychology would suggest that people are motivated to form gangs and groups because they share a similar or common goal (Crisp and Turner, 2007). As such, four specific group sub-types are possible: loose associations of people, social categories, task groups, and intimacy groups (the most group like). This theoretical grouping model is useful when analysing the prison-based psychological drive to form gangs, each with their somewhat own unique culture and language usage.

The formation of prison gangs is an area of research which has recently been well documented, particularly by US-based academics. Wood and Adler,

(2001) and Wood (2006), however, provide limited confirmation of this phenomenon in English prisons. To summarise, driven by a need to adapt, prisoners at times take on a set of behaviours that are appropriate to their group membership. For the marginalised, or socially disadvantaged, in the external community, prison can present a society, in which, paradoxically, the physically strong and resourceful assume positions of considerable power in the prisoner hierarchy (Pollock, 2006). Here, the author described a prison world which represents society inverted in relation to the wider society showing that those who are frequently powerless on the outside, by reason of their ethnic group, economic, and/or criminal status, are often held in high esteem inside the prison.

Unseen by the external population, prisoners live within this complex new community, with codes and rules which punish those who transgress (Morello, 1961; O'Donnell and Edgar, 1999; Rivera *et al.*, 2003; Rosen, 1990). The formation of gangs/groups can, at times, form a protective unit, and at other times, will administer violent retribution to those who are considered worthy of attack, thus causing further (physical and/or mental) health damage (Lahm, 2008). One of the key lessons to be drawn from this area of the literature is the re-occurrence of major themes in prisoner gang/group debate (de Lisi and Walters, 2009; Gillespie, 2002; Lawson and Ward, 1996; Sykes, 1958). The decision to include pseudo families was made, as these largely female groups share many of the characteristics of a prison sub-culture, yet follow their own distinctive feminine form of the inmate code. As such, they are likely to have affected previous access to healthcare.

The literature presents many reasons for female gang formation. As early as 1996, Giallombardo found that women prisoners form close emotional, familial links with each other, and 86% of the study's sample reported that this experience had become sexual in nature. This later found support in the journal article *Contemporary Patterns of Female Gangs in Correctional Settings* (Lauderdale and Burman, 2009). Unlike male prisons, however, the formation of female gangs went largely unnoticed by the prison staff. They are, as a result, likely to be under-reported, under-recognised, and under-researched.

Pollock (2006) argued differently that women are motivated to form pseudo families due to the subservient role they play in wider society. This argument was contradicted by Huggins *et al.*'s study in the same year, *Deviants or Scapegoats: An Examination of Pseudofamily Groups and Dyads In Two Texas Prisons*, which found that out of a sample of 214 participants, the primary driver for gang membership, accounting for 50% of participants was the ability to hug someone and not feel alone.

Further, it must be acknowledged, it is ironic that women form family groups as this was the social unit in which many would have been abused as children. However, notably, the pseudo family theory is not universally accepted. In 2000, Greer, for example, argued that a perception of motherly behaviour may be no more than an outward manifestation of the mistrust permeating all interpersonal prison relationships. Here, the prison social setting is convoluted, and includes a variety of invisible facets that new inmates must learn and adapt to swiftly.

Regardless of the sub-culture to which prisoners are members, it is also important to recognise they belong to wider prisoner society, or meta-prisoner group (Rosen, 1990). Here too, rules exist. Within an "elusive world of jail law" (p. 24), the author found that prisoners are not permitted to *blag* or talk to the authorities. Punishment is metered out for cohorts despised in the prison population. Goods are sold and exchanged, and the purchase of drugs and alcohol is widespread.

The plight of the mentally ill in prison was highlighted by Gostin (2007), in a participant observation study. The author argued that the care provided is abusive and reinforced the stigma of mental illness through the misapplied stereotype of *dangerousness*. Posing as a pseudo patient under a US Department of Justice, Gostin covertly entered what he later described as a "brutal, inhumane institution for the criminally insane" in Easton North Carolina (2007, p. 907). Through this experience he found that, despite isolated pockets of excellent practice, the majority of institutions delivered a cycle of neglect and punishment of the mentally ill imprisoned there.

For English prisoners too, HMCIP for England and Wales (2009) identified that in half of male local and training prisons inspected, and in all the women's prisons, primary mental health remains inadequate or non-existent. This issue continues to highlight a fundamental inequality in mental health service provision, supporting Adams and Ferrandino's (2008) argument that this group posed a significant challenge to professionals.

It is difficult to imagine how the mental health of prisoners can be improved during a period of incarceration. The prevalence of prisoners with profound levels of mentally ill health in England is well documented (Brooker *et al.*, 2008a, 2009b; Chitsabesan *et al.*, 2006; Edgar and Rickford, 1999; Singleton *et al.*, 2005). More recently, it has been asserted that prisons are being used inappropriately to house these individuals due to a lack of appropriate facilities in the community (Shaw, 2007). For others, it is argued that their underlying illness was a factor that led them to commit the crime for which they have been incarcerated (Turner, 2000; Yorston, 2004). The danger of the criminal justice service goals and the healthcare needs of the mentally ill, it is feared, could also come into direct conflict (O'Grady, 2004). The ongoing care versus custody furore is relevant here.

Shaw's (2007) assertion that prisons have become the new *institutions* housing the vulnerable, finds wide support (Bradley, 2009; Brooker *et al.*, 2008; 2008b; Docherty, 2009; Hayward *et al.*, 2008; HM Inspectorate of Prisons and Youth Justice Board, 2009; Home Office, 2007; Rösler *et al.*, 2009; Yorston, 2004). From the very earliest observations of Howard (1784), prison campaigners have argued that prison is not an inappropriate place to house the mentally ill. These recent studies add significant weight and support for this assertion.

2.9 Impact on Prisoner Health

This thesis considers that the promise of equitable healthcare within a Public Health framework is to be commended as a worthy pursuit. Notwithstanding this praise, whether this was ever a realistic ambition for the imprisoned patient population is a matter for serious consideration and research analysis.

Government policies, outlined in Chapter One, promised significant benefits to NHS patients. Amongst these were:

- a system of integrated care (Department of Health, 1997)
- a reduction in the health gap between the least well off members of society (Department of Health, 1998a)
- high quality care regardless of where patients lived (Department of Health, 1998)
- pooled budgets for health and social care (Department of Health, 2000a)
- support tailored to the realities of people's own lives (Department of Health, 2004)
- increased emphasis on prevention and early detection of disease (Department of Health, 2006a)
- a reduction in variation of the quality of care given to patients (Department of Health, 2008b)

These promises made to the external population were applicable to prisoners also (Department of Health, 2004). The data collected by this thesis shows nothing to suggest that, when newly charged commissioning and delivery commenced, PCTs understood or fully appreciated the enormity of this task.

It could further be offered that in the context of prisoner health literature, the promise of equality care for all patients in the NHS, regardless of where they reside (Department of Health, 1998), is over-simplistic. There is overwhelming verification that prisons do not contain a representative cross-section of the external population. Instead, prison establishments contain, amongst others, the very young as well as a large number of people who have suffered social injustice and are, as a result, chronically sick, disabled, mothers with dependent children, the dying, elderly, addicted, intellectually disabled, mentally ill, unable to speak or understand English, as previously considered. As a result, their underlying health status is likely to be poor. Equity in healthcare demands that on humanitarian grounds, healthcare policy and practice must be able to overcome these underlying disadvantages.

These issues are multifaceted and are further complicated when one reflects that the literature suggests that many of the most vulnerable amongst the prison community, have previously suffered years of abuse and neglect prior to their imprisonment (Sachs-Ericsson, 2009). As a result, a considerable number will have long-established psychological and behavioural issues. Here too, the Prison Service houses a large population of these individuals.

The argument that prisons are inappropriately used as a community care facility for the most vulnerable members of society was put forward by Shaw (2007). Whilst there is no doubt that people with serious and long-term mental health conditions or personality disorder (Ullrich *et al.*, 2008), are over-represented in prison, less agreement exists about concrete policies which may have contributed to this. More specifically, any direct link between this phenomena and deinstitutionalisation (Salize *et al.*, 2008), termed *transinstitutionalisation*, cannot be clearly identified in the literature. Reviewing both sides of this argument, Prins (2010) recommended that a more nuanced approach was required to both explain this issue, and develop effective policies to divert this group back into community-based treatment facilities.

Other vulnerable people in our prisons, it must also be recognised, are all members of minority sub-communities whose needs can be, and often are, overlooked. Edge (2006) and Corston (Home Office, 2007) both argued that the minority status of imprisoned women, in particular, could be missed in a prison system designed principally for men. It has indeed been argued that, for the majority of women, their sentences could be better served in the community (Carlen, 2002; Carlen and Worrell, 2004; Home Office, 2007).

Completing the classification of vulnerable cohorts, HM Inspectorate of Prisons Youth Justice Board (2009) also found that 24% of young men and 49% of young women in custody reported being in care at some time in their lives prior to imprisonment. In the same report, a significant 88% of young men and 89% of young women had been previously excluded from school. The difficult life experiences of these young people and their inexorable progress to incarceration are important areas for further consideration, as this is likely to have been detrimental to their health.

Government policy to provide *equivalent care*, this review has found, is further challenged by the hidden informal rules that exist behind the prison walls and amongst the prisoner population. Within this complex prison landscape, prisoners must adapt, provided they have the mental capacity and awareness to do so. Some clearly do not (Bradley, 2009). The literature presents a prison world in which people live in a web of cultures and sub-cultures (Lauderdale and Burman, 2009; Rivera *et al.*, 2003). They also have their own customs, values (Ireland, 2009; Wolff and Shi, 2009), languages and beliefs (Einat and Einat, 2000; Hensley *et al.*, 2003; Kurtz, 1981).

Amongst these, the powerful belief that to “trust” previously outlined, is considered here to be dangerous. This is not conducive to effective healthcare delivery or rapport with healthcare clinicians (Howerton *et al.*, 2007, p.7). The challenge for providers of prison healthcare to overcome these entrenched prejudices is extreme, and this review has found no literature to suggest they have been successful thus far in this respect.

Newly formed PCTs were, therefore, presented with the task of both commissioning, and, in some cases, providing equivalent care to a convoluted patient/prisoner population, a large number of whom had neglected their own health, or suffered abuse, prior to imprisonment, and was distrustful of the new regime. Although this review has found examples of isolated pockets of good practice and service delivery, the promise of equitable healthcare provision to the prison population as a whole is not apparent, to date. The following concluding section details these variations and remaining areas for research and development.

2.10 Conclusion

The Public Health Agenda for England provided a valuable framework mechanism against which the literature relating to prisoner health could be considered. It also formed the overarching theoretical framework for this chapter.

Together with PSO 3200, Public Health Policy in England promised a great deal of positive ramifications. In particular, it provided a clear set of priorities for the improvement of prisoner health and laid the foundation upon which equitable healthcare should be delivered.

This literature review set out to establish whether, despite the best of intentions, these ambitions could be delivered to prisoners. Considered at the overt and surface level, the Public Health Framework has credibility: health promotion, health education, disease prevention and healthy settings all combining to facilitate better health. At a policy level, therefore, this framework is valuable for consideration in the prison context.

At the more practical level of policy implementation, however, this review has identified that the framework is beset by a wide range of prison-based problems. Amongst these, largely attributed to a difficult and somewhat socially excluded life journey prior to imprisonment, are numerous barriers which cannot easily be overcome in the prison environment. These include:

1. Addiction to drugs, alcohol or both,
2. Base line prisoner health data largely absent,
3. Chronic ill health present in this population,
4. Community Care failure leading to inappropriate imprisonment of the vulnerable,
5. Education – low levels of achievement and high school exclusion rates,
6. Health screening, vaccination and preventative health services little used by this population previous to imprisonment,
7. Life experience for many prisoners leading to a lack of trust of healthcare professionals,
8. Mental illness and learning disability overly present,
9. PCT lack of knowledge and expertise,
10. Prison overcrowding at acute levels,
11. Prisoner-prisoner rape and sexual attack,
12. Sub-populations with unhelpful cultural norms and behaviours,
13. Unsuitable prison environment for long-term sick, vulnerable, physically disabled and frail elderly.

Within this intricate health, social, cultural, and political penal landscape, the Government placed the responsibility for health improvement and healthcare delivery into the hands of individual NHS clinicians and local organisations (Department of Health, 2004). PCTs were also charged with the provision of healthcare services which were broadly similar to those provided to the external community. It is important to establish whether either of these ambitions were realistic, and would lead in time to real improvement in prisoners' health.

Here, the epidemiological and prisoner cohort specific nature of much of the literature leaves gaps in the ability to identify this population's overall experience. For example, transgender and/or homosexual prisoners are largely missing from the literature. At an establishment level, the chronic overcrowding, access difficulties and financial pressure on English prisons, have led to a situation in which insufficient national, generic, first-hand, whole-system research has taken place, post-transfer to NHS responsibility. The experience of imprisoned patients, given the lack of contemporary base line data set for its underlying state of health, must be established before any judgement can be made about the successes, or otherwise, of these endeavours.

Thus, this study aims to address this literature gap and to explore with prisoners themselves their experiences of NHS health provision post-implementation of these new NHS arrangements.

CHAPTER THREE: METHODOLOGY AND METHODS

We cannot approach society, or social facts, as we do objects and events in the natural world, because societies only exist in so far as they are created and recreated in our own actions as human beings... [W]e cannot treat human activities as though they were determined by causes in the same way as natural events are

Giddens (1987, p. 11).

3.1 Introduction

This study explores how imprisoned patients experience NHS healthcare in English prisons, as well as their perception of whether healthcare equity has so far been achieved. A qualitative, interpretative single-Case Study, within the wider methodological interpretative approach was adopted in order to explore the complex research phenomena from its varied prison contexts.

Participant correspondents who took part in this study were Category (Cat) B (restricted status), High Security, Local Female, Local Male, Male Cat B, Male Cat C, Male Cat D, Young Offender Institute and Miscellaneous Status prisons.

Fieldwork commenced with semi-structured interviews which were conducted with prison staff to include, for example, the Head of Healthcare in Cat B, C and D prisons, Lord Ramsbotham at the House of Lords, the Prison Ombudsman at the Ombudsman's Office London, and a recently-released young offender. Focus groups and a discussion group were held in Male Cat B, C and D, and a Female Cat D prison.

Ontology (the study of the nature of being) and epistemology (the study of knowledge), are the important philosophical considerations and foundations of this thesis and provide the introduction of this chapter. A reflection on the Anti-Foundationalist / Constructivist / Interpretivist position adopted is presented

initially. This is followed by a justification for the rejection of positivistic, quantitative scientific methods, as these routes of data collection were considered inappropriate for the social world being explored.

To discover prisoners' experiences, Case Study Method supported by Colazzi's (1978) Seven Procedural Steps Method, was selected as the appropriate methodological framework for this work.

Section 3.10 starts a detailed description and debate of the research methods used. Qualitative Focus Groups and Qualitative Interviews were selected as the appropriate in-depth means for exploring participants' experiences of the research area of interest.

The application of these methods appears in specific Phases, from One through to Five (for the purpose of clarity), and to demonstrate the application of these during fieldwork. The process pertinent to each of the five phases is discussed in-depth, followed by a presentation of the graphic and visual material generated during this study. Data collection and the use of the analytic framework selected will be included within this debate.

The chapter presents discussions regarding ethical considerations, validity, generalisability and transferability, and concludes with a justification of the sample size selected. Bias will be considered in Chapter Four.

3.2 Ontology and Epistemology

The question of whether a stable reality exists, regardless of our awareness or knowledge of it, has long divided the opinion of prominent philosophers. This is the primary concern of ontology (Green and Thorogood, 2009). Broadly speaking, opposing opinion falls into two camps, which are:

1. Foundationalists / Positivists / Empiricists
2. Anti-Foundationalists / Constructivists / Interpretivists

Those academics adopting a Foundationalist position argue that an absolute world of *objective truths* exists. Commonly seen as realists or objectivists, opinion is then further divided in this field of Foundationalism. For epistemological positivists (broadly defined), this nature of measurable *truth* is somewhat limited. For epistemological realists theory plays an important role in the interpretation/s of truth and/or reality. Notwithstanding these divergences, the existence of an objectifiable reality and a set of truths is acknowledged.

Despite the undoubted advances of scientific endeavour within this tradition, considerable debate has been generated regarding whether it can provide all the answers (Grbich, 2007). Indeed, it has been argued that many qualitative research methods have been developed in the context of a critique of quantitative methods (Flick, 2009).

Four broad epistemological traditions are accepted to impact upon qualitative research. Grbich (2007, p. 1) posits that, within the following categories, claims for “truth” have been made:

- Positivism / empiricism
- Critical emancipator positions
- Constructivism / interpretivism
- Postmodern and poststructural positions.

Flick (2009, p. 24) is highly critical of the increasing isolation of quantitative method and that of Guba and Lincoln (2005) in particular for resurrecting, what he considered to be “trench fights”. More helpful to this central methodological debate, however, (Flick, 2009, p. 24) posits that the continued discussion has established this debate on “different levels:

- Epistemology (and epistemological incompatibilities) and methodology;
- Research designs combining or integrating the use of qualitative and quantitative data and/or methods;
- Research methods that are both qualitative and quantitative;
- Linking findings of qualitative and quantitative research;
- Generalisation of findings;

- Assessing the quality of research – applying quantitative criteria to qualitative research or vice versa”.

Further, Grbich (2007, p. 1) considers that postmodernism and post-structuralism during the past 40 years have also impacted the data display and positions taken by both the author and the reader.

In contrast, the Anti-Foundationalist / Constructivist / Interpretivist methodological position is that no *objective true world* exists. Still, this should not be confused with a denial of innate, material, physical structures. This school of ontological thought argues that the social world is entirely a social construct. Here, three common features are identified by Guba and Lincoln (1994), namely:

1. The position varies between individuals and groups, essentially taking a local, specific view of reality. Constructs are ontological elements of reality.
2. People actively construct the world through the lens of their own fixed values and opinions.
3. Individual constructs are formed after the observers own views have been shaped by political, social and cultural processes.

Therefore, “this ‘reality’ has no, [*sic*] social role/causal power independent of the agent’s/group’s/society’s understanding of it” (Marsh and Furlong, 2002, p. 191).

This thesis adopts the Anti-Foundationalist approach to methodology. It rejects the Foundationalist position, as this more *scientific* method is not considered appropriate for exploring, interpreting and researching a world that is socially constructed (with a multitude of influencing factors: economic, political and social). Additionally, the notions regarding the *meaning* of health equity are numerous, and are critiqued by interested academics, health policy analysts and discourses. Therefore, this work considers the research objects (the nature of health equity broadly defined) from these diverse and multiple angles.

3.3. Study Questions

3.3.1 Initial research questions

Chapter One introduced this study's initial research question formulated from the policy narrative presented:

What is prisoners' experience of healthcare in England post-transfer to NHS responsibility, and has the policy promise of equitable healthcare provision been achieved in the penal setting for this patient group?

Informed by the literature review, and attentive to this study's ontological position regarding the nature of social reality, this initial research topic is now refined to provide two overarching study questions.

3.3.2 Overarching Study Questions

1. In what ways has the policy promise to deliver equitable healthcare been (re)constructed and experienced by imprisoned patients?
2. Considering the findings from this research, can NHS policy be effectively formulated and practiced for this chronically sick and disadvantaged incarcerated patient population, and then, can equitable healthcare be coherently and consistently constructed within NHS policy in tandem with its construction by the patient prisoner population?

3.4 Study Design

Pierce (2008, p. 43) lists four core attributes often ascribed to qualitative research which are central to this study with its emphasis on imprisoned patients' constructed healthcare experience:

1. "Inductive analysis that is premised on discovering categories and being exploratory with open questions.
2. Holistic perspective that seeks to understand all of the phenomenon and the complex interdependence in issues of interest.
3. Qualitative and adaptive data collection based on detailed thick description and depth, for example analyses direct quotation to capture

unique perspectives and experiences. The research design is adaptable to changing situations and has the ability to pursue new paths of discovery as they emerge.

4. Empathetic neutrality in doing research is important as most qualitative researchers believe complete objectivity is impossible. The researcher's agenda is to understand the complex social world with empathy, while also attempting to be non-judgemental".

The discovery and interpretation of prisoners' healthcare experiences have remained the focus of this study since its inception in 2005. Driven by a commitment to deliver *broadly equivalent* (Joint Prison and National Health Service Executive Working Group, 1999) NHS provision to this new patient population, this policy promise underpins the overarching study questions.

Initial exploration of this field of research indicated that showcasing prisoners' healthcare experience requires the representation of many diverse perspectives. These should be discovered through the application of systematic social investigation. Selection of appropriate methodology and methods, with the sensitivity to engage with, and amplify the voices of this marginalised community is, therefore, vital to the ultimate worth of this thesis.

The numerous methodological challenges arising from this should not be underestimated. The first such challenge relates to the difficulty of implementing equitable healthcare policy in the prison environment illustrated in the opening chapter of this study. From a theoretical perspective, healthcare policy creation and implementation was thought to be of equal importance (Ham, 2004). The voice of those demanding the new policy landscape for imprisoned patients in England was not, however, equal in strength. Prisoners' own voices were notably silent.

This lack of involvement of the very people affected by the policy imperative seems, at best, undesirable. At worst, this failure to effectively listen could mean that potential barriers to effective implementation were not identified and overcome. As such, the success of these endeavours may ultimately be undermined.

From these considerations, the first overarching research question was constructed:

In what ways has the policy promise to deliver equitable healthcare been (re)constructed and experienced by imprisoned patients?

Further, the equitable healthcare policy considered here was required to be delivered within the Public Health Agenda. This demanded a concerted, positive approach to healthcare access, and the adoption of health-promoting behaviour of this new NHS patient group. Here too, gaps in knowledge exist. The critical analysis of the literature indicates that prisoners are often treated by investigators as a homogenous sample group, or generic community. Much is written about poor prisoner health *per se*. What is written is often presented as epidemiological or statistical data and comparatively few studies are written from prisoners' own perspectives. Even less is known about the challenges this new NHS patient population face when accessing healthcare services within a secure environment.

What is known relates instead to broader prisoner culture, language, addiction and underlying levels of disease. Individuals with mental health issues have received particular academic attention. What is less known, again, is whether this impacts prisoners' ability to access and use NHS services.

Do security constraints, for example, affect the choice, waiting times and range of medication/services offered to imprisoned patients? Do those serving a life-sentence experience different issues to those on remand? Are services provided within a moral, legal and ethical framework, or do imprisoned patients experience discrimination and prejudice on their healthcare journey? What are imprisoned patients own hopes and fears for healthcare for the future? Ultimately, when asked, will it ever be possible for this sick, disadvantaged and distrustful community, to vocalise their healthcare experience effectively, or at all?

Without the amplification of the underlying social experience of these new patients, there is a real risk that the implementation of equitable healthcare policy for prisoners may, at the very least, fail to achieve its full potential. From

these considerations, the second overarching research question has been constructed:

Considering the findings from this research, can NHS policy be effectively formulated and practiced for this chronically sick and disadvantaged, incarcerated patient population, and, then, can equitable healthcare be coherently and consistently constructed within NHS policy in tandem with its construction by the patient prisoner population?

Here, despite the challenges in accessing this vulnerable and seldom heard community, this study will explore the lived experience of imprisoned patients and construct their social reality of their healthcare experience in the penal setting.

3.5 Methodological Framework

Epicentral to this topic is the human experience of participants, for whom reality is constructed by subjective perception and then interpretation. Thus, the interpretive paradigm and approach to data collection and analysis provides the most appropriate method in order to explore these experiences. Flick (2009) argues that in generating knowledge, it is important that, the researcher reflects on their own research as part of the generation of knowledge process.

Regarding researcher reflexivity specific to this study, the researcher recognises herself to be part of the political, social, economic system which created the relevant NHS policy, leading to the transfer of prison healthcare occurring. Thus, the researcher's interpretation of the data will, inherently, be firmly embedded (and constructed) within this social context. This, in turn will be further interpreted by others who are also part of the wider social and political context. This study is, therefore, double-hermeneutic and acknowledges that multiple perspectives of the research *reality* it debates do exist (Duncan, 2005). It is also important to highlight here that participants also are embedded within the social world researched, observed, and analysed (Smith, 2005).

Qualitative tools, often employed by Anti-Foundationalists, are challenged by Denzin (2000). Indeed, he suggested that, without first being personally immersed in the phenomena, it is impossible to experience emotions or transport the reader into the world of the study.

The approach adopted must enable readers to better understand and access this particularly hard-to-reach prison-based community which is so isolated, in fact, that Patenaude (2004) described remote Alaskan communities as being easier to reach. Denzin and Lincoln (2008), however, posit that remaining faithful to the phenomena under study and their idiosyncrasies is more important for valuable qualitative research than specific, rigid methodological techniques/approaches. Instead, the emphasis must be on the context within which the research is conducted.

The underlying poor health and difficult life experiences of this patient population, as discussed in the literature review, adds a further level of complexity to conducting this study. Described by Morse (1994, p. 32) as a “board game of wits”, the author argued that insight in social research can only be collected through a process of continual engagement or re-contextualising with the study’s data. Only then can theory, the most important outcome of qualitative research, be achieved (Morse, 1994). Therefore, for this thesis, repeated engagement with the data constructs one main theoretical argument:

Equitable healthcare will not be experienced by imprisoned patients unless they are meaningfully engaged in the design and implementation of an integrated prison health and social care service strategy.

The paucity of first-hand, generic, national prison data specific to the research interest renders this study distinctive. This work, therefore, approaches the research phenomena with limited prior understanding and theory. This complexity signalled that the approach adopted during the fieldwork phase would need to be recursive.

Interpretative methods vary considerably, and several would be considered epistemologically appropriate for this study. Selection of method, however, should be guided by the nature of the study itself and its aims (Stern, 1994).

3.5.1 Case Study

This study commenced with an attempt to understand how the policy promise of equitable healthcare narrated in Chapter One is experienced by imprisoned patients. Here, their social construction of prison healthcare, both individually and collectively, is assumed to be shaped by the political and philanthropic endeavour previously described. Additionally, the chronic ill health and disadvantaged characteristics prevalent in this population, in tandem with the inaccessible and secure nature of their environment presented noteworthy methodological challenges requiring sensitive solutions. Not least of these was the two-dimensional nature of the healthcare policy and its implementation within the Public Health Agenda presented in Chapter Two. Within these well-meaning, but largely mechanistic, frameworks, imprisoned patients view NHS provision through the lens of prison culture and reconstruct their social reality. An approach with the power to construct a three-dimensional understanding of this complex landscape was, therefore, required and Case Study was considered.

Case Study is technically not a methodological approach. Described by Foucault (1981, p. 6) as a “polyhedron of intelligibility”, Case Study offers an opportunity to explore a single issue in-depth from a number of angles. The Case, therefore, presents a three-dimensional picture of the research phenomena examined, and is considered valuable for intensive, in-depth investigations (Yin, 1981, 1994, 2003, 2004). Thus, it is increasingly employed in the field of social science (Gomm *et al.*, 2000).

As with all research methods, Case Study has attracted criticism. One frequent criticism claims that the results are not “widely applicable in real life” (Tellis, 1997). The method is, thus, seen as unscientific in nature, subjective, lacking research vigour and generalisability, or transferability of findings. This critique comes from sections of the research community with an opposing methodological approach, upholding different values.

Case Study pays attention to *how* and *why* something happened (Yin, 1994). It is also concerned with *what* happened and how the constituent parts are connected. It is not, however, interested in an orthodox approach to generalisation, inviting thus criticism for its lack of *scientific* rigour (Mays and Pope, 1995). Those supporting this approach argue that it is not intended for quantification or wider generalisation (Yin, 2004). Its focus instead is the capturing of the uniqueness of the phenomenon under study (Gomm, *et al.*, 2000). This was termed by Yin (1994) as the holistic, meaningful characteristics of real life. Each chapter of this study, therefore, uniquely contribute to and enable improved understanding of the Case in question.

Green and Thorogood (2004) argue that in qualitative work the logic of generalisability is rather different. Done properly, qualitative research should be capable of producing an in-depth description rather than an account which is immediately generalisable to other studies (Green and Thorogood, 2004).

In this situation, the goals of this study are discovery and interpretation, rather than hypothesis testing and generalising. However, part of the interpretative approach should be consideration of whether research findings will prove true for other groups and settings (Polit and Hungler, 1996). The inability to apply research findings in this way has long been considered a shortcoming of the Case Study approach. Yin (2004), however, argues that the Case Study as a unit is akin to an experiment in some aspects. Under this consideration, the requirement to generalise becomes no different to generalising the findings of quantitative research experiments.

The application of the researcher's own subjective thoughts to the collection of data is also emphasised (Yin, 2004). Thus, reflection on the study's substantive issues, dedication to carefully collect data and ensuring the study is not unduly influenced is extremely important to this thesis.

The criticisms of Case Study are widely refuted in the literature by Yin, Feagin, Stake and others. Case Study, it is asserted, can build on and add to a body of knowledge (Morra and Friedlander, 1990). It is further posited that the use of a single case is supported when the phenomenon is unique and

previously inaccessible, making it ideal for studies of this kind where the research population is particularly difficult to access (Liebling, 1999).

Methodologically, Case Study offers valuable initial boundaries to this work comprising two parts: firstly, a research subject and, secondly, a valuable analytic framework (i.e. prisoners' experiences of equitable healthcare). Ensuring that the analytic framework is right for the Case is emphasised by Thomas (2011). The author argues that appropriate selection should ensure that nothing is lost in refraction, "enabling the reader to hear the sound of human voices" (Thomas, 2011, p. 7).

Significantly, Case Study is bounded by a time period relevant to the research phenomena (Yin, 2004). The time period selected for this study is 2002-2010. It commences, therefore, at the point of the first-wave transfer of prison health to NHS responsibility. It concludes five years after the final prison transfer took place. This temporal aspect enables sufficient fieldwork data to be collected for in-depth analysis, understanding, and meanings to be constructed.

Utilisation of the Case Study approach is justified for this endeavour as it fits and aids the aim of this study and its research questions. Therefore, its adoption is apt.

3.5.2 Theoretical Framework

The selected theoretical framework (regarding analysis and generation of knowledge) selected provides, at its best, an essential structure to facilitate and enable understanding of the perspectives and positions of imprisoned participants. It is intended that the Case selected will be interpretative. It corresponds, therefore, to the wider methodological interpretative approach of this study. As such, this study asserts that the social world is essentially indivisible from its multiple contexts, and should be explored, observed and analysed in its complexity.

Table 6 presents this theoretical framework, based on Thomas's (2011) model which has been selected for this study:

Table 6
Thomas's (2011) Model

The following table shows the Case Study approach adopted by this study.

Key = Indicates approach taken by this study.

Subject	Purpose	Approach	Process
Outlier	Intrinsic	Testing a theory	Single
Key	Instrumental	Building a theory	Multiple
Local	Evaluative	Drawing a picture	nested
	Explanatory	Descriptive	parallel
	Exploratory	Interpretative	sequential
			retrospective
			snapshot
			diachronic

Application of Thomas's definitions (2011, p. 95):

- *Local*, relates to the researcher's personal knowledge and previous experience in accessing this research population.
- *Instrumental*, as this study is concerned with events within a specific (previously defined) time period.
- *Evaluative*, as a specific policy intervention was introduced for this population. This study is interested in whether this has achieved equitable provision for prisoners (in accordance with prisoners'/patients' experiences).
- *Explanatory*, in the sense that this thesis presents a case which has the ability to explain relevant issues to others in the field.
- *Theory*, as it is concerned with theoretical construction, but only specific to this study. It will do this as a means of understanding what effect NHS policy has had on participants. In this sense, it is only intended to be a temporary conceptual framework or thinking tool, solely for the purpose of this study.
- *Multiple*, case for this study (i.e. the prison establishment) unequivocally demonstrates the numerous research phenomena under study.

The paucity of experiential, national, generic English prison research in this field presents a challenge to this study. The lack of prior national, generic data impedes our understanding of how these powerful elements combine to contribute unique knowledge within the case (i.e. the prison setting). Therefore, it is necessary to gather authentic, rich data from multiple sources. Without it, there is a risk that prisoners' experiences and the history of English health policy in the penal setting will remain inadequately documented.

Much of the fieldwork for this study was intended to be conducted inside prisons, and ethnography was, as such, considered. Within this approach, participant observation was given particular attention. Conduct of anthropological endeavour, it is argued, necessitates a theoretical focus and framework prior to a researcher entering the field (Stern, 1994). As previously stated, this is not possible for this field of academic health research, as it is relatively under-researched; therefore, this model was not feasible. Further, the intensive long-term nature of much ethnographic fieldwork made it impracticable due to generic time constraints, as well as that permitted in the prison environment. Moreover, as this work is concerned with some form of a future for a national response/perspective, the sample-limiting nature of ethnography made it unsuitable.

Early conversations with prison staff also indicated that an application to conduct a long-term participant observation study from inside a prison would be rejected both on practical and security grounds. The primary requirement of ethnography, that it always involves prolonged direct contact with participants, could not, therefore, be achieved (Boyle, 1994). Ethnography was rejected on these grounds.

Phenomenology, the study of the lived experience of humans to investigate subjective phenomena (Moran, 2000), was also considered. Developed by Heidegger, interpretive phenomenology emphasised interpreting and understanding, rather than simple description of human experience.

It is argued that studies can fail to grasp the philosophical understanding of the phenomenological approach. Ray (1994) posited that studies in the

nursing literature were particularly culpable of this. Criticising Lincoln (1992), and Lincoln and Guba (1985), the author claimed that phenomenology had been wrongly used to refer to the qualitative paradigm. Although qualitative, this study is not phenomenological in nature. Attempting to focus on *prisoners' experiences of healthcare* provision, this study is in no sense concerned with the phenomenological focus on *what it is like* to experience.

The national sample selected for this work also exceeds the number of 8-12 participants principally involved in the same experience, as required by this method (Ray, 1994). This approach was also rejected.

3.6 Data Collection Theory and Principles

3.6.1 Choice of Research Methods

Having considered the methodological approach in section 3.1 and refined research questions in section 3.3.2, the selection of the most appropriate method of data collection is now considered.

Case Study research demands a wealth of rich participant material derived from multiple and varied sources (Yin, 2004). Collected, analysed and presented correctly, it is argued, that readers should be able to “smell the very breath of participants” (Thomas, 2011, p. 7).

Research methods available were divided broadly into *quantitative*, favoured by a Positivist epistemological position, or *qualitative* methods usually favoured by a Non-Positivistic academics. Methods, such as triangulation (Mathison, 1988; Shih, 1998), and studies that employ both quantitative and qualitative methods (Morse: 2005; Morse, 2008), can also be combined as appropriate.

Much has been written about the relative strengths and weaknesses of each, and the debates are far from straightforward. Prior to the 1960s, social science research had generally followed the more natural scientific empirical tradition. The pursuit of identifiable, and quantifiable *social facts*, forms the epistemological foundation of this paradigm (Burns, 2000). Defined as

positivism, this approach has now largely been rejected as inappropriate for the study of the subjective, experiential social world of human subjects (Bynner and Stribley, 1978), where the idea of *truth* is bound by human caprices (Burns, 2000).

3.6.2 Interviews

The researcher's own ontological position is that *participants' experience of healthcare post-transfer to NHS responsibility* is meaningful asset for the phenomena that this study is designed to explore. Generating data on this ground is, therefore, justified within the epistemological position adopted. Interviews provide an in-depth means through which a participant's understandings, memories, attitudes, feelings and personal experiences can be explored (Vromen, 2002).

Termed "conversations with a purpose", Burgess (1984, p. 102) asserted that interviews are much more than a simple gathering of data through participants' articulations. In this case, the analysis of verbal discourse alone would not be substantial enough. Indeed, although deployed extensively, interviews have proved somewhat difficult to define. There is, for example, criticism of the conversation approach. Here, it is argued that one's ability to verbalise may be affected by many things including memory failure or an inability to conceptualise (Mason, 2002). The author posited that rather than uncovering something which already exists outside of the interview, knowledge is actively constructed through the process of social interaction in the field.

Interviews have been described as a particularly valuable tool when eliciting understanding of how large-scale social change impacts the lives of individuals (Gerson and Horowitz, 2003). The authors argue that the particular interview style is largely informed by the cognitive style demanded by the methodological approach adopted. To be successful, considerable forethought and planning is required prior to entry into the field. Critically, the appropriate selection of a target population with the capability to "illuminate the issues under analysis" is essential (Gerson and Horowitz, 2003, p. 204).

The methodological challenges inherent in penal research are inextricably linked to the underlying disease, health and social disadvantage and addiction

prevalent in this population. Academic studies primarily utilising interview in the field can be seen to be influenced by these factors. Broadly speaking, interview-based studies fall within six categories:

1. Addiction – to alcohol, drugs or both,
2. Disease and infection transmission,
3. Frameworks or programmes - the usefulness thereof,
4. Mental ill health,
5. Population cohorts - adolescents, black and minority ethnic, older people and women,
6. Violence.

This body of literature is extensive and methodologically diverse. However, taken collectively, there is an increasing level of understanding of the ill health and poor life experience of this population. This supports many of the issues previously highlighted in Chapter Two (Bradley, 2009; Braveman and Gruskin, 2003; Condon *et al.*, 2008; Fazel *et al.*, 2005; Hayward *et al.*, 2008; HM Inspectorate of Prisons Youth Justice Board, 2009; Moran and Peterman, 1989; Prison Reform Trust, 2003; Stewart, 2007; School Exclusion Unit, 2002). Further, there is growing awareness of the wider potential risk to society of prisoner non-compliance with penal substance misuse, anti-violence and mental health promotion programmes.

Without exception, all of these studies reported the chaotic lifestyles of research participants, access difficulties in the field and significant methodological challenges arising from these problems. In almost every case, interviews were administered alongside a range of other pre-existing screening tools intended to elicit socio-demographic or underlying variables. A limited number of these studies offer valuable insight to this study.

The first group of interview-based studies focusing on specific prisoner cohorts were mainly conducted in America. Here, concern about levels of addiction and violent or disruptive behaviour is particularly prevalent. It is not possible to ascertain from the academic papers presented (Ramchand *et al.*, 2009), whether this focus primarily arose out of a concern for the young people themselves or were examples of *legitimate* issues (Ham, 2004) described

previously in the theoretical framework for Chapter One. Likewise, the broader community may also have recognised that failure to act on these issues would ultimately impact its own health and wellbeing, as highlighted by Ramsbotham (1996). These important health policy-related issues are not, however, discussed in the studies selected, and conclusions on these matters would prove unreliable.

What is apparent within the work presented is an underlying theoretical framework, suggesting that difficult life experiences and disadvantage alongside social exclusion issues can lead to substance addiction for many people. Later, these same individuals are likely to be incarcerated (Moss, 2003), supporting earlier findings in the English literature (Joint Prison Service and National Health Service Executive Working Group, 1999). At the level of analysis, a clear dichotomy emerges between studies with a theoretical interest in the addicted and damage to selves and others arising from this. Secondly, the experience of vulnerable and marginalised groups within the criminal justice system attracts significant research interest.

At a theoretical level in the field of penal research, the use of the interview method presents a number of challenges. Not least of these is the “anxiety and confusion” for researchers collecting and analysing this material, sometimes for the first time (Packer, 2010, p. 57). Highlighting the paucity of connectivity between underlying theory, the research question and chosen approach, Packer (2010) is critical of a lack of instruction available to novice researchers embarking on this approach. Confusion about which issues are significant, or important, to include for later data analysis, is another factor adding yet further complexity to this area of research (Packer, 2010).

These dilemmas occur because, at a theoretical level, interviewing methodology presents a range of valuable opportunities for researchers to formulate research problems in numerous ways. Diverse studies, such as those considered here, offer the researcher a wealth of rich material which can be used for the later generation on theory. Thus, interview-based endeavour presents a valuable opportunity for this research.

Similar to the wider prisoner research, many penal interview-based studies have been conducted in America. It is important, therefore, to exercise caution before applying the research findings to the English prisoner population. The studies included here (Friedmann *et al.*, 2008; Ramchand *et al.*, 2009;) have not been selected for their applicability. Instead, they offer a valuable insight into some of the diverse research tools and forms of analysis deployed in the field. Further, these studies highlight some of the specific difficulties associated with the use of these research tools within a secure environment. Considered carefully, these works offer an opportunity for this study to learn from the collective academic knowledge in the field, and ideally avoid many of the difficulties highlighted. As is often the case in prison research, the focus or population of these studies overlap to some degree, and should be viewed in this way, rather than considered to be entirely separate areas of study. Indeed, the challenges of the interview-based research method are inextricably linked to the regime, culture and population characteristics previously identified (Hensley *et al.*, 2003; Patenaude, 2004).

Other findings also support the wider literature. Ramchand *et al.*'s., (2009) study, *Seven-Year Outcomes of Adolescent Offenders in Los Angeles*, deployed field-based interviews with 449 adolescents at 3, 6, 12, 72 or 87 months post-baseline data collection. The successful deployment of the research method found data to support the theoretical proposition that unchecked violence and addiction pose a threat to society. This confirmed previous findings, including a number of English studies (NACRO, 2004b; Social Exclusion Unit, 2002). These issues are of importance for society and the young participants in this study, as Ramchand *et al.*'s study found that age-related mortality for this group exceed the expected norm for the population by 500%.

Since this study was conducted post-release, many of the access difficulties prevalent in penal research did not present an issue. Also, in this case, and with many American studies, a large number of participants were directly recruited through Federal programmes or initiatives. This differs significantly from the experience of English penal research where academics report significant access barriers (Liebling, 1999; Patenaude, 2004).

The deployment of structured interviews alongside the use of pre-existing screening tools has been found to be successful in penal research. This is particularly the case when socio-demographic and prison-specific background information has also been used (Friedmann *et al.*, 2008; Jansson *et al.*, 2008; Reyes *et al.*, 2006; Tuetsch *et al.*, 2010).

There are a limited number of interview-based penal research studies which were conducted in countries other than America. Tuetsch *et al.* (2010) for example, recently explored hepatitis C infection amongst Australian prisoners. In a longitudinal study, 488 participants were interviewed about behavioural and demographic risk factors leading to potential transmission. The interview technique used here again proved a valuable tool for identifying that, after controlling for socio-demographic characteristics, infection was found to be positively associated with behavioural factors. Notably, this was found to be the case with the practice of prison tattooing.

These studies offer evidence of a clear strategic approach to an underlying theoretical research proposition. Here, addiction is seen to drive violent and disruptive behaviour. Further, they highlight the value of the co-operative approach to prisoner research between the criminal justice system and those entering the field. This collaboration is often evident in American studies, but less evident elsewhere where access is often restricted. Thus, a range of interview based techniques can clearly be seen to *illuminate* prisoners' underlying behaviours which significantly impact the effectiveness/non-effectiveness of the treatment programmes offered. These findings add additional support to the issues previously highlighted by academics studying prisoner behaviour (Einat and Einat, 2000; Glaser, 1967; Kurtz, 1981; Pollock, 2006; Rosen, 1990; Wolff and Shi, 2009; 2004).

Qualitative interviews can offer a valuable and flexible research tool for facilitating and generating qualitative data which is suited to this study, its aims, and underpinning methodology.

This is the case particularly for the following participant cohorts:

- Individual prisoners/patients
- Prison staff
- Prison NHS healthcare staff

The generation of this data from multiple sources for later analysis and consideration corresponds to the requirements of the Case Study model adopted (Yin, 2004). Essentially, it would build the “polyhedron of intelligibility” required (Foucault, 1981 p. 6). However, the studies highlighted demonstrate the particular value of deployment of interviews alongside other mechanisms for data collection. This has particularly been found to be the case for the utilisation of prisoner health and offending data, socio-demographic background information thus allowing comparisons to be made across a range of factors. In the case of this study, the lack of detailed prison population health data does not allow similar exploration. This is not considered detrimental to the research, however, which is concerned instead with prisoner perception of their health experience.

Interviews alone can be an insufficient method to elicit the experiential data required. For example, Gerson and Howowitz (2003) argue that the best qualitative studies utilise both interview and observational approaches. This requirement, however, placed a significant demand on a study of this kind which is concerned with a difficult-to-access population. Instead, focus group method was used.

3.6.3 Focus Groups

Access to this study’s participant population was severely challenged due to the security constraints placed on prisons, their staff and prisoners. It was considered unfeasible to conduct a large number of one-to-one interviews with individual prisoner participants. This limited access differed considerably from the American research experience previously described. Collective interviews, otherwise known as focus groups (Morgan, 1988), were considered instead.

Originating in American marketing through the work of distinguished sociologist Robert K. Merton, focus groups have more recently been described

in the marketing literature as an opportunity to “zero in on the fuzzy” (Goebert and Rosenthal, 2002, ix). More broadly, focus groups are widely described in the literature, and are variously presented as organised discussions (Kitzinger, 1994), combined effort (Powell *et al.*, 1996), and social activity (Goss and Leinbach, 1996). What unites focus groups is that they differ from other group discussions in the sense that they “focus” on some form of collective activity (Kitzinger, 1994 p. 103), and determine what is salient about it (Morgan, 1988a).

This ability to concentrate attention on a single point of interest has led in recent years, to effective application of this method in research (Crawford and Acorn, 1997; Dolan *et al.*, 1999; Johnson, 2006; Kitzinger, 1994; Klercker and Zetraeus, 1998; Owen, 2001; Pope and Mays, 2006; Vaughn *et al.*, 1996). There is also a limited body of literature which demonstrates successful application in the field of international penal research (Chang *et al.*, 2010; Carlin, 2005; Devine *et al.*, 2007; Donovan, 1996; Hartwell, 2003; Leukefeld *et al.*, 2009; McNabb, 2008; Minc *et al.*, 2007; Wolf *et al.*, 2004), and national penal research (Bennett *et al.*, 2010; Bryan *et al.*, 2007; Nurse *et al.*, 2003; Plugge *et al.*, 2008). These studies vary widely but, taken together, would support Morgan’s (1988) argument that focus groups are valuable both alone, or as a complimentary research approach particularly where triangulation and validation are required.

Drawing heavily on the work of Goldman’s (1962) article *The Group Depth Interview*, Stewart *et al.* (2006 p. 8) describes four key “theoretical pillars” of this approach:

1. Focused Research

The Focus of group attention on a particular phenomenon of interest;

2. Group Interactions

Providing an opportunity through the observation of group dynamics, to better understand individual perception and decision making;

3. In-Depth Data

Ability to yield in-depth answers to research questions that are incremental in nature;

4. Humanistic Interview

Emphasis on immersion into individuals lived experience and emphasis on meaning.

Zaltman's (2003) argument that human thought is largely visual and metaphorical in nature meant that the application of non-verbal techniques would be essential for the success of a shared understanding of the research issue. The methods section that follows will present the application of metaphorical graphic icons and a graphic board developed to facilitate this facet of the fieldwork.

In favour of focus groups, the opportunity and practical aspects of facilitating these, when compared to individual interviews, can appear to be a relatively 'cheap and quick' option. However, Morgan (1988) describes this as a myth. This seems to be particularly the case when participants are considered to be vulnerable (Owen, 2001) or hard-to-reach (Gibbs, 1997; Morgan, 1988). Highlighting the complexity of this method, Stewart (2006, p. 2) further argued that a "one-size-fits-all" approach would be insufficient.

Moreover, the underlying argument that focus groups are of particular value where a power differential exists between group members (Krueger, 1993) has also been challenged. The creation of an environment in which participants are freely able to discuss their thoughts on the subject has been considered of paramount importance (Milena *et al.*, 2008). This should not be confused with what Stewart (2006) describes as a widespread assumption that the experience should be pleasant for those taking part. Conflict, however, should not necessarily be avoided and, for some focus group participants, their experiences will be less than empowering (Gibbs, 1997). For others, reciprocity with the researcher, and an opportunity to speak aloud their issues is liberating (Goss and Leinbach, 1996), leading to an opportunity to create real change (Race *et al.*, 1994). These behaviours will manifest in the fieldwork.

Empowered by the graphical presentation of emergent research themes, participants enthusiastically embraced the opportunity to be heard. They spoke powerfully and with great clarity about their healthcare experience to date, as well as their care and treatment wishes for the future.

Although in a Focus group situation the researcher has less control over the data generated, there is, conversely, an excellent opportunity to observe group behaviour (Morgan, 1988), and a richness of research material (Stewart and Shamdasani, 1990). It is cautioned, however, that *group effect* (the impact of like-minded individuals on other group members) might create a situation where the behaviours of participants could be quite different in a group situation (Myers and Lamm). To counter this, Carey and Smith (1994) suggest that it is essential for researchers to keep the context of the group interaction in mind as they analyse their data.

Thus, taking a polyphonic approach in a collective interview situation to generate a broader spectrum of view, it has been argued, could elicit differences in participant opinion (Fontana and Frey, 2005). The authors argued that under no circumstances should the researcher push participants into a position where they feel it necessary to make life decisions concerning the research issue. Instead, more important and relevant is the opportunity for individuals to accept or reject the views of others (Stewart, 2006). By so doing, there will be an opportunity to take the research into new areas of interest and interactions, which is considered a key strength of focus groups (Kitzinger, 1994). Again, in the fieldwork phase that followed, participants readily accepted, as well as rejected, views of their peers. Focus group members were forceful in their opinions, frequently speaking in their own prison *Argot*, and displaying none of the characteristics of group effect previously described.

Organising focus groups requires more planning than with other methods (Gibbs, 1997). It has also been demonstrated that the skills and experience of the researcher are particularly important in ensuring the group's likely success (Kitzinger, 1994). Webb and Kevern's (2001) asserted that in nursing research, methodological discussions often lack sufficient analysis or critique. Therefore, the absence of researcher skill could lead to discussions which were commonly superficial (Webster and Kevern, 2001).

Adopting the role of 'moderator' to encourage group participations, Krueger (1998) stressed that this required an ability to stimulate open dialogue without the application of one's own judgement or opinion. Here, the literature broadly

agrees that individuals adopting this role are not expected to be experts on the discussion topic (Baker and Hinton, 1999; Vaughn *et al.*, 1996). Indeed, more recently, Stewart (2006) argued that the over-questioning of group members has lessened the quality of the interaction.

Focus groups when combined with other research methods, it has been asserted, are particularly useful in the exploratory stage of research endeavours (Powell and Single, 1996). There is a growing body of research demonstrating the flexibility of focus group method in the field of penal research and a number of studies have particular relevance for this thesis.

In the international field of penal research, five such works representing a variety of application and methodological approaches offer useful insight for the developing of the research framework of this study (Carlin, 2005; Chang *et al.*, 2010; Leukefeld *et al.* 2009; McNabb, 2008, Moss, 2003; Wolf *et al.*, 2004).

Supporting Morgan's (1988) assertion that focus groups are particularly valuable when deployed alongside other research tools, Chang *et al.*'s (2010) work exemplifies a particularly labour intensive study. A psychiatrist and a community health nursing lecturer acted as moderators. These were supported by two co-moderators to audio tape dialogue and observe group behaviour. A total of 6 prisoner focus groups were held, involving 77 male participants from the previously unexplored Taiwanese prison population. The study identified prisoners' thoughts of resentment towards a recently implemented smoking ban, and drew attention to the powerless state of the imprisoned when policy was implemented without their involvement or consent.

These issues are relevant to this study. Examples of active prisoner involvement in the decision to transfer prison healthcare to NHS responsibility, previously discussed in Chapter One, were not identified. This policy decision was taken on the clear assumption that this was beneficial for imprisoned patients, without anyone appearing to ask them whether this was the case. Clearly, focus group method promises much in the research endeavour to identify and report prisoners' own views on these complex health-related matters.

In contrast, McNabb (2008) explored gendered violence amongst American women prisoners. Although details about participant involvement were not published, data analysis indicated that violence amongst women prisoners could quickly escalate to dangerous levels once initiated. These findings are interesting, as the majority of women in English prisons are reported to be held due to non-violent and petty offences (Home Office, 2007). As such, they may pose little threat to themselves and others (Home Office, 2007). McNabb's (2008) study might, therefore, offer a valuable area for future research to determine whether there are any context-specific factors in English prisons that render this so or, whether there is emergent evidence that English female prisoners are becoming increasingly violent.

Moss (2003) collected data from staff working with American incarcerated women alongside on-site technical assistance groups via a staff survey. It was identified that between 40-88% of imprisoned women had suffered physical/sexual abuse or violence prior to incarceration. This "trauma" (Moss, 2003, p. 2) found to have been left untreated, leading victims into later substance abuse and incarceration. The 48% range of these findings raises questions about the reliability of the data collected. Further, it is reported that imprisoned women are reluctant to report their issues or to seek assistance from figures in authority (Easteal, 2001; Rosen, 1990). The Moss (2003) study is likely to have been similarly affected by this underlying mistrust.

It is unknown on what basis the author's decision to employ this research strategy was made. It might illustrate the difficulty in gathering first-hand access to prisons themselves (Patenaude, 2004). One valuable mechanism to overcome these barriers is conducting data collection post-release, or in less secure environments. Leukefeld *et al.* (2009), for example, explored drug treatment with recently released parolees. Participants were divided into a series of sub-panels to generate initial research ideas. These were followed by nine quarterly focus groups aimed at identifying the complexity of re-entry. Wolf *et al.* (2004) also explored prisoner *re-entry* but used the term differently to mean *re-integration*. In this case, the authors concluded, that prisoners were not adequately prepared for their release, and showed a lack of specific services to assist the recently released.

A limited, but valuable number of British studies have also deployed focus groups successfully (Carlin, 2005; Nurse *et al.*'s; 2003; Plugge *et al.*, 2008). These studies demonstrate the particular flexibility of the focus group method, making it valuable in penal research which is often iterative or recursive in nature.

In the case of Carlin (2005), a single focus group was used alongside semi-structured interviews. Prisoner participants expressed a perception that prison staff were more interested in the control of heroin and the maintenance of order, rather than their own health and wellbeing.

Plugge *et al.*, (2008), however, held six focus groups involving 37 women, in two womens' prisons in the south of England. 12 semi-structured individual interviews were also conducted. Thematic analysis indicated that the women had varied views about the quality of prison healthcare and many perceived its quality to be poor.

A number of issues were highlighted as particularly problematic. These were: poor access to care and medication, breaches of confidentiality on the part of healthcare professionals, and experiencing disrespectful staff attitudes. Women participants also believed that prison healthcare staff were less qualified than external staff. To introduce some of this research data, the themes highlighted here will later be confirmed amongst the 24 identified by this study. The adoption of a similar research approach will, therefore, prove successful with imprisoned participants.

To conclude this sub-section, the challenge of conducting focus groups in prisons was considered seriously. This research method proved to be a convoluted endeavour in the penal setting. Nevertheless, on reflection, the benefits outweighed the disadvantages, as the data collected for this thesis is suitable in addressing its questions.

3.7 Implemented Analysis Process

To reiterate, this study implements a qualitative, interpretative, single-Case Study within the wider methodological interpretative approach.

The national focus of this study necessitated a significant quantity of research data. The selection of a suitable analytic framework for qualitative data with the capability to synthesise a large volume of diverse material was, therefore, essential.

The gathering of rich data from multiple sources is also demanded by the Case Study approach (Yin, 2004). This further informed the data collection priorities. Yet, it is argued that the analysis of Case Study is one of the “least developed aspects of the Case Study methodology” (Tellis, 1997, p.8).

Dixon-Woods *et al.* (2005) highlight 11 possible approaches for the synthesis of qualitative research evidence. Pope *et al.* (2007, p. 45), however, caution that the explanation for such diversity rests with differential labelling of:

[...] what are in essence the same methods; some linked to the inevitable process of adapting methods in practice... Notwithstanding this, synthesis is a rapidly developing area of research methodology and one in which new techniques are likely to emerge in the future.

This study is concerned with taking our understanding of imprisoned patients’ experience of healthcare beyond the epidemiological or the descriptive. It is, therefore, insufficient to know about the ill health prevalent in this population (Bradley, 2009; Braveman and Gruskin, 2003; Condon *et al.*, 2008; Fazel *et al.*, 2005a; Hayward *et al.*, 2008; HM Inspectorate of Prisons Youth Justice Board, 2009; Moran and Peterman, 1989; Stewart, 2009; Yorston, 2004).

Indeed, the “polyhedron of intelligibility” previously highlighted (Foucault, 1981, p.6) demands much more. It requires multiple and varied data sources, if the Case Study is going to be effective. Here, an understanding of the cultural and environmental factors (Clemmer, 1958; Cropsey *et al.*, 2007; de Viggiani, 2007; Fazel *et al.*, 2001; Hensley *et al.*, 2003; Johnson and McGunnigall-Smith, 2008; Patenaude, 2004; Pollock, 2006; Spelman, 2009) are also considered essential to our constructed awareness.

Likewise, the promise of equitable provision enshrined within the document *The Future Organisation of Prison Healthcare* (Joint Prison Service and National Health Service Executive Working Group, 1999), is equally important. Therefore, the careful design of a methodological framework for analysis which is capable of fulfilling these requirements is essential.

There are four qualitative approaches to research design (Grbich, 2007):

1. Subjective
2. Investigative (semiotic)
3. Enumerative
4. Iterative (hermeneutic)

Data saturation through a process of continual feedback is considered central to the production of meaning within the iterative position (Grbich, 2007, p. 20). Here, the continual entry to the field and critical reflection via continual data collection and analysis builds what is termed by Grbich (2007, p. 237) as the “recursive spiral”. This process of continual collection, adjustment, design and modification, should arrive ultimately at the construction of *meaning*. At this point, the research question is considered to be answered.

This qualitative research design approach also reflects the assertion that within Case Study, a good researcher is akin to a detective. Thus, entering the field devoid of theory, the social scientist carefully constructs meaning to their observations over a period of time and from a multiplicity of resources (Grbich’s, 2007, Yin, 2004). These approaches guided this study. Fieldwork and analysis will be fully described in Chapter Three, Methods section, and Chapter Four.

As previously discussed, focus groups provide a particularly valuable opportunity to explore single points of interest in health-related and penal research (Carlin, 2005; Chang *et al.*, 2010; Devine *et al.*, 2007; Leukefeld *et al.*, 2009; McNabb, 2008; Wolf *et al.*, 2004).

3.8 Interpretive Approach to Evidence Synthesis

There is a range of approaches considered appropriate to the interpretive synthesis of qualitative data. The ability to combine data from multiple sources in the same discipline or within different research designs is considered a key strength of these approaches (O’Cathain and Thomas, 2006). In some qualitative studies, a number of methods are employed, as is the case here. Essential to success is ensuring that these methods are informed by the theoretical perspective which provides the framework for the research. Here, the applicability of Grounded Theory was explored and will be discussed in the section to follow.

3.8.1 Grounded Theory

Grounded Theory, developed by Glaser and Strauss (1967), is the development of theory through the systematic, intensive analysis of extensively coded data. Although a distinct difference between the underpinning theoretical approaches taken arose later between the authors, the primary emphasis on *grounding* data for in-depth consideration and elaboration remains undisputed.

The framework for grounded theorists is rooted in Symbolic Interactionism (Stern, 1994), where the researcher attempts to determine the symbolic meaning which artefacts pose for people and groups as they interact. From this, the researcher attempts to construct what interactants see as their social reality (Stern, 1994). This too corresponds well to the methodological approach adopted by this study.

Thomas and James (2006) argue that Grounded Theory is popular because qualitative inquiry is difficult to perform, and this framework aids analysis for researchers. These authors were critical of this approach, however, and posited that what materialises is *invention* rather than discovery. The approach is criticised for dismissing the direct validity of participants’ own original accounts.

This criticism challenges the validity of selecting Grounded Theory for this research, as the Theory is concerned with the direct experiences of

participants. Lacking sufficient prior first-hand qualitative material, prisoners' own words are, therefore, of central importance.

Despite its criticism, Grounded Theory offers here a useful framework for conceptual analysis of data generated within the case, as well as an opportunity to categorise these into theoretical propositions. To strengthen the link between Theory and participants' direct accounts, Colazzi's (1978) Seven Procedural Steps Framework will also be applied. Of particular value, Colazzi's Framework does not fracture the link between participants' meaning and what was actually narrated in the focus groups (Sanders, 2003). The words of those taking part, and not the researcher's perception of what they meant to say, as in Grounded Theory, will remain intact. The generation of research questions within a Case Study approach will also be applied to select the Cases in this complex area of study. The analytic process will be presented in-depth in Chapter Four.

Coding plays an essential part in the qualitative data analytic process, and there is a wide repertoire of coding methods available to researchers. Patton (2002) promotes a pragmatic approach, whereby the coding technique is selected as the most appropriate for the research project. Within qualitative inquiry, a code is used as something that symbolically assigns "a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data" (Saldaña, 2008, p. 3). Coding can, therefore, be either simple data summaries, or attribute more evocative meanings to the data depending on the methodological orientation and theoretical frameworks employed.

Coding is not, however, a neutral act. It requires researchers to wear an "analytic lens" (Saldaña, 2008, p. 6). As a consequence, the data collected is perceived, interpreted and filtered through the underlying methodology. In this study, the researcher, as a grounded theorist, used *In Vivo* Coding to root data in participants own language.

The passage below represents a single example of coded data taken from the Imprisoned Carer Theme:

*"H and me have a system,
if he needs me he bangs on the wall.*

Code 4

Prior to the application of codes, the researcher must also select their level of involvement from a range of options (Adler and Adler, 1987). Regardless of whether the coding applied is descriptive or conceptual, Merriam (1998, p. 48) asserts that the findings of a study will reflect the constructs, concepts, language, models and theories that structured the study in the first place.

This is ultimately a subjective process (Saldaña, 2008; Ziebland and McPherson, 2006). Qualitative research, however, has been subject to claims that it lacks analytic rigour (Bryman, 2004). The inclusion of deviant cases that contradict the evolving themes are, therefore, worthy of inclusion. Patton (2002) proposed that in order to ensure rigour, themes must be repeatedly reviewed against emergent data holistically. Thus, the premature interpretation of data can be avoided (Toch, 1971).

This approach is compatible with a process of constant thematic comparison with each data section across the study's database. Thus, the interaction between emergent concepts, existing literature, social context and early theorising of data, build what Glaser and Strauss (1967) term the first *substantive theory*. Thus, at this early stage, concepts generated are specific to the research focus: imprisoned patients entitlement to broadly equivalent NHS provision.

Formal theory (Glaser and Strauss, 1967) develops through the process of continual data collection and thematic analysis. Grbich (2007, p.190) describes this process as transporting emerging, explanatory concepts to "the realms of formal theory". Here, the concept is linked to all similar situations, building conceptual, rather than measured, relationships. Theory is, therefore, built iteratively rather than being generated *a priori* and then subjected to investigation. Diagrammatic representations of this process will be presented in Chapter Four in order to illustrate.

Thus, through a continual process of evidence and contradiction, theory, the ultimate aim of this study is built (Yin, 1994). Disagreement will be used to influence, and develop thematic construction continually as the study progresses.

Focus group data can arise from three types (Duggleby, 2005):

1. Individual data
2. Group data
3. And/or group interaction data

Yet, despite this general recognition, there is considerable disagreement between theorists about which of these is the appropriate unit for analysis. Although the emergence of particular research themes are considered valuable as they yield important and interesting information, Onwuebuzie *et al.* (2009) assert that these can censor the voice of outliers. Thus, the inclusions of dissenting information, these authors argue, “increase the descriptive validity, interpretive validity, and theoretical validity of the phenomena of interest” (Onwuebuzie *et al.*, 2009, p. 7).

There are many forms of focus group analysis, ranging from the moderator’s recollections (Kruger, 1994) to transcript-based analysis which is considered to be the most rigorous and “time-consuming method” (Onwuebuzie *et al.*, 2009, p. 4). Despite this, these authors assert that regardless of the abundance of published material on conducting focus groups, “scant specific information exists on how to analyse focus group data in social science research” (Onwuebuzie *et al.*, 2009, p. 4).

In response, Onwuebuzie’s research resorted to a new qualitative framework for collecting and analysing focus group data, *Micro-interlocutor Analysis*, during the field work stage. This is designed to work with full transcripts of field notes, rather than limited/abridged analysis which only records those portions of the literature which assisted the researcher in answering specific research phenomenon. The authors asserted that this framework takes qualitative research beyond the simple analysis of focus group participants’ verbal interaction, thereby, the rigour of focus group analysis is increased.

It is unfortunate that the authors' framework for data collection and analysis had not been published until the focus groups stage in this study was concluded. Although retrospective analysis using Onwuegbuzie *et al.*'s (2009) framework was considered, it was in the end discounted on the grounds that the researcher's recollection of focus group interaction in the required detail would have fragmented by this point. Theoretically, Onwuegbuzie could have added to the richness of experiential data collected for this Thesis. As such, it is an unavoidable limitation to this study.

Concluding this section, an appropriate approach to data gathering has been determined and described previously. Data analysis was undertaken on field notes, interview transcripts and participant correspondence within a grounded theoretical approach and will be supported by Colazzi's Seven Procedural Steps Framework. Qualitative data analysis software NUD*ST, N6 and N7 were used to support analysis, as shown in Chapter Four.

3.9 Ethical Considerations

This study was conducted within the British Psychological Society's *Ethical Principles for Working with Human Participants Framework* (The British Psychological Society, 2005).

Prisoners are a complex and often hidden community. It must be recognised that participants in this study are firmly embedded within both the physical and cultural context of their environment (as cited in King and Wincup, 2008). The Literature Review further highlighted the poor health and difficult life experience many prisoners have had prior to their entry into prison. Low levels of literacy, learning difficulties and lack of education compound this. It is essential, therefore, that prison research is conducted in a sensitive and ethical manner in order to exclude the exploitation of vulnerable people, and empower this social group in a meaningful sense to participate in the research.

The approach adopted is based on the consultation document *Involving Marginalised and Vulnerable Groups in Research* (INVOLVE, 2003),

(INVOLVE appears in capital letters to distinguish it from an organisation with the same name).

Bower and De Gasparis (1978) stated that participants will speak most truthfully if they believe their contribution will be held in confidence. Thus, a large volume and range of information sheets and posters were generated, in order to both inform participants regarding the purpose of the study, and also to advise them that their confidentiality and anonymity would be preserved.

Research suppositions were clearly laid out for potential participants before the study commenced and communicated repeatedly to participants.

Although the work was inductive and set out on a journey to explore prisoners' experiences of healthcare in England with no hypothesis, there was, from the outset, a clear research goal, namely, to *identify whether equitable provision had been achieved for this population*.

Within the framework for this study, the researcher recognised that the appropriate person from whom permission to conduct fieldwork in the prison environment should be sought was the prison governors (being the ultimate authority for all activity in their establishments). This had been the advice of the Department of Health for a previous study conducted by the researcher (Tabreham and Whiteside, 2005). In addition, it was also considered the correct approach for this research.

Arguably, participants should be provided with an opportunity to participate in the *long-arm* (correspondence) aspects of studies such as this. Moreover, acknowledging that penal institutions are increasingly difficult to access, this approach was also considered valid in a previous study conducted by Bosworth *et al.* (2005).

The complexity of obtaining the required permissions and rights of access is something recognised by members of the penal research community (Connolly and Reid, 2007). The authors argued that research participants themselves should be involved in regulatory decisions. This notion conforms with the current national framework for *patient and public involvement*

(Department of Health, 2002b). Treating people/patients as experts in their own right, whilst working with them to ensure they are not abused via research is arguably the way forward for prison research. The complexity behind this apparently simple statement should not be underestimated.

The following section considers the selection of a qualitative approach to data creation, as well as the use of participant correspondence interviews, and focus groups as the most suitable methods for this study.

3.10 Methods

Research methods must be relevant and appropriate to the study's methodological position, aims and theoretical framework.

A discussion of ethical approval, participant recruitment and data collection will also be considered.

3.10.1 Background to this Study

The rationale for this research originated from the researcher's involvement in a previous study (Tabreham and Whiteside, 2005), in which imprisoned patients demonstrated considerable variation in their healthcare experience.

An early review of the literature found few first-hand prison studies exploring this issue. The voice of prisoners themselves was largely absent from the field of research and knowledge. This study has been designed to address this gap through methods of direct access to participants.

The rationale for the selection of a qualitative approach was chosen to obtain this data was explained previously in section 3.1. In sections 3.10, 3.11, 3.12, 3.13, 3.14 and 3.15 to follow, methods used in this study are discussed in detail. Key points arising from this will then be summarised.

3.10.2 Formulating the Initial Stage of this Research

Due to the lack of previous similar studies, the fieldwork adopted an exploratory approach, and was not directed specifically by existing literature.

The generation of a national data set, derived directly from the research population was vital, as this was to inform future data collection and analysis. This led to the initial stage of this study, to elicit prisoners' experience of healthcare in England post-transfer to NHS responsibility. The process of selection, recruitment and access will be discussed in detail in section 3.11.

3.10.3 Research Timetable

The table below details the research timetable for this study.

Table 7
Research Timetable

Month	Year	Activity
October	2005	Research outline
November	2005	Research proposal submission
November	2005	Department of Health notified and permission to conduct study sought
December	2005	Application for ethical approval University of Lincoln
December	2005-2010	Literature review
January	2006	Department of Health permission granted
February	2006	Ethical approval granted CCAWI (Centre for Clinical and Academic Workforce Innovation) University of Lincoln
September	2006	Call for participants <i>InsideTime</i> article
October - December	2006	Phase 1 data analysis

February	2007	Validation group
May	2007	Focus Group A - men
June	2007	Young person interview
October	2007	Focus Group B – women
November	2007-2009	Phase 2 data analysis
September	2008	Health Service Journal article
October	2008	Carer Interview
June	2008	Interview Head of Healthcare Men's Local Prison
February	2009	Multi-agency visit Prison Elder's Group
August	2009	Interview Acting Head of Healthcare – women's prison
September - July	2009-2010	Writing up

3.10.4 Research Model

The following model illustrates the research process for this study. Phases One to Five will be discussed in detail in the sections to follow.

3.11 Phase One

3.11.1 Objective

The specific objective of Phase One was to identify key patient themes of interest with a self-selecting national sample.

Phase One involved:

- Submitting a research proposal to the University of Lincoln
- Obtaining Local Research Ethics Committee (LREC) approval to conduct this study

- Obtaining national permission from the National Patient Involvement lead Department of Health
- Establishing data storage facilities
- Installing N6 qualitative analysis software and undertaking training
- Identifying sample prison population
- Placing advertisement in prisoner newspaper *InsideTime*
- Collection of prisoner correspondence
- Data analysis
- Commissioning a graphic artist to produce icons for research themes identified
- Creation of graphic icons

A detailed research plan outlining this study's aims and suppositions was submitted to the University of Lincoln in November 2005, and was accepted by the research supervisors.

3.11.2 Ethics Approval

Local ethical approval for this study was granted by the Centre for Clinical and Academic Workforce Innovation, the University of Lincoln on the 28th February 2006.

3.11.3 National Approval and Permission

In discussion with the research supervisors, it was determined that the Department of Health was the appropriate body to grant permission to conduct this study. Details of the intended work programme and access requirements arising from this were submitted to the National Head of Patient Involvement in November 2005. Permission was granted on 30th January 2006 (see Appendix C).

3.11.4 Qualitative Data Analysis and Storage

After reviewing a number of qualitative research packages, QSR N6 was purchased to support this work. Coding, retrieval and analysis will be discussed in Chapter Four.

Data storage facilities were established on the researcher's employer's mainframe computer system. Paper records were securely locked in the

company's basement archive facility in a compartment reserved for the sole use of this study.

3.11.5 Identifying Phase One Prison Sample

The intention was to collect and analyse data simultaneously through a series of interim analysis (Yin, 2004).

Analysis of these early Phase One issues would form a comprehensive thematic data set for later exploration entirely consistent with the Case Study analytic framework employed.

3.11.6 Recruitment of Participants

In the early stages of fieldwork, it became clear there was no such thing as a single prison population. Instead there was a complex world of cultures and sub-cultures, inhabited by people who lived by prison codes, pseudo-families, or neighbourhood communities, and all of whom spoke a language of their own, prison *Argot* (Hensley *et al.*, 2003).

Rules of behaviour in the prison, both written and unwritten, had to be observed. Participants made personal judgements about whether they were prepared to invest their time in engaging with this study. Several explicitly said so. This experience was shared by Patenaude (2004, p. 72) who observed:

[...] it is amazing how many research opportunities are lost or severely limited by a poor first impression made to a gatekeeper (either staff member and/or inmate) in a criminal justice agency.

To be eligible to take part, participants were required to reside (or have recently resided) in either private or public prisons in England in receipt of NHS health care. Others should be employed in a capacity supporting imprisoned patients in receipt of healthcare. Participation was open to all genders, ages and ethnic backgrounds. Participants should be capable of giving their informed consent.

Drawing on successful previous experience, an advertisement was placed in *InsideTime* inviting them to share their view.

3.11.7 Open Letter Calling for Participants Phase One

In September 2006 the *InsideTime* article invited readers to say whether the transition of prison healthcare to NHS responsibility had made a difference to their experience of using health services in prison. A number of other questions were posed:

- What is your opinion of healthcare provided in prison?
- Are there issues you face in trying to access healthcare in prison?
- Has being in prison affected your health in any way?
- Have you got any suggestions for ways in which prison healthcare could be changed and does the category of prison you are in raise any particular issues for the way healthcare is delivered?

Conscious of prisoners' limited resources, a freepost address was published to save participants the cost of a stamp (which for some represented in excess of 10% of their weekly wage). Letters received were marked with the name of the prison from which they were sent. A range of information sheets and posters were generated to both inform participants about the purpose of the study and advise them that their anonymity would be preserved.

The use of a pseudonym to protect researcher identity was also considered. This was rejected as previous work arising from this thesis was published without the use of this method (Tabreham, 2008).

Before initiating contact with participants, advice was sought regarding the protocols to be observed when approaching and entering prisons. The advice given highlighted the danger of *conditioning* (the practice of prisoners influencing the naive for their own purpose). This risk was largely mitigated by previous specific training given by an experienced prison guard.

Further instruction included the necessity to wear trousers as many of the prison landings are open metal grills. Flat shoes were required to prevent heels becoming stuck in these or to enable escape should it become necessary to run. In the later phases of this research, only the graphic board, pens and notepads were permitted to be taken into each prison. Computers

and mobile phones were not allowed, and later it was advised that the carrying of a mobile phone within the prison had become a criminal offence.

In the initial phase of this study a total of 67 letters were received from participants in response to the article posted. A full description of data analysis and findings are presented in Chapter Four.

Despite the reported low level of literacy of this population (Prison Reform Trust, 2003; Social Exclusion Unit, 2002), Phase One, as anticipated, generated a large quantity of rich material. It is regrettable that the literacy difficulties of many potential participants meant that some are likely to have been unable to participate.















3.11.8 Phase One Data Analysis

The initial fourteen themes generated through participant correspondence in Phase One were analysed using Colazzi's (1978) Seven Procedural Steps Framework. A full description of this process is presented in Chapter Four. Themes identified are:

1. Access to specialists
2. Complaints
3. Dispensary opening times
4. Drug misuse
5. External support
6. Healthcare facilities
7. Healthcare staff
8. Medical records–assessment
9. Medication
10. Prison regulations
11. Privacy
12. Treatment
13. Variation in healthcare provision
14. Waiting times

The themes identified above were turned into graphic icons to assist with communication for the phases of this study that followed.

Table 8**Phase One: Graphic Icons**

Access to Specialist 	Complaints 	Dispensary Opening Times 	Drug Misuse 	External Support 	Health Care Facilities 	Healthcare Staff 
Medical records 	Medication 	Prison Regulations 	Privacy 	Treatment 	Variation in Healthcare Provision 	Waiting Times 

3.12 Phase Two**3.12.1 Phase Two: Objectives**

The process of recruitment and validation group in the second stage of this study is discussed in sections 3.12.2 and 3.12.3. The specific aim of Phase Two was to convene a group of participants in order to explore their response to the fourteen themes identified in prisoner letters above. Further, it was also intended to obtain participants' perspectives on their own healthcare experiences.

Phase Two involved:

- Designing participant information and publicity materials (see Appendices E and F)
- Informing prisons and obtaining governor's permission
- Recruitment of participants
- Construction of graphic board

3.12.2 Validation Group Procedure

The validation group was established to enable participants to confirm or reject the initial themes identified in Phase One of this study. True to Case Study approach requirements, this research was prepared to return to Phase One

and repeat it had participants not corroborated with initial interpretations. The study would have been amended as required.

3.12.3 Informing Prisons and Obtaining Governor's Permission

It was necessary at this stage to contact prison governors and request permission to hold the validation and focus groups in their establishments. Various methods were employed, such as letter, email and telephone conversations. Governors in every prison in England providing NHS care to prisoners were sent participant information (see Appendices D, E and F). They were also assured that this study was anonymous, and that their prison or individual participants would not be identified.

Only one prison governor agreed to arrange the validation group and did so because he had previously worked successfully with the researcher. He personally arranged for participant posters and information sheets to be distributed throughout the prison.

The participating establishment was a male prison, housing a number of high-risk inmates. Although granted lone access to the group, it was considered necessary that proceedings would be watched at all times by a prison officer on a television screen in an adjoining office.

Prior to the commencement of the group, a research statement of the aims and purpose of the study was read aloud to participants (see Appendix D). Participants were again asked whether they wished to continue. One man chose to leave when it became clear the group could not discuss or address his individual healthcare complaint.

To aid understanding of the initial research themes identified through Phase One participant correspondence, these were developed and produced in graphic icon format. This would help those who had literacy or language issues. Further, the application of this non-verbal technique satisfies Zaltman's (2003) requirement for non-verbal techniques to aid the visual and metaphorical nature of human thought.

Figure 4

Graphic Board

Prison Healthcare

- Complaints**: no flexibility, is pointless
- Dispensary opening times**: CLOSED
- Access to a specialist**: I want to be here
- Healthcare Staff**: "Excellent", lot of training, don't have a choice
- External support**: waiting times, 1 year waiting for surgery
- Waiting times**: Horrendous, permanent, not too long
- Patient records**: LOST, delayed, NHS = reduction in prison deaths
- Healthcare facilities**: variation of provision, sense of ownership
- Prison Regulations**: we have a stake in it, a difference
- Medication**: access to outside help, toothache, Here doctors do it properly
- Privacy**: what's privacy, other prisons, such thing
- Treatment**: illegal drugs, clinics, diabetic tests, 30 hours behind door made condition worse
- Lifer**: treated as people HERE, good if the rest leave from the good bits here

Figure 5
Carers Graphic Icon



3.13 Phase Three

3.13.1 Phase Three Objective

To enable focus group participants to take part and share their own perspective on their experience of prison health care, three individual focus groups of prisoners were initially intended; this were to include male, female and young people. Despite writing to all young offender institutes in England permission to hold a young person's focus group was denied. A decision was taken to substitute a semi-structured interview with a recently released young person instead. Two focus groups were therefore held, one in a male prison and one in a female prison.

Phase Three involved:

- Obtaining governors' permission
- Obtaining participants' consent
- Training note-taker

Focus group interviews were conducted by the researcher with the addition of a graphic artist as mentioned previously. At the men's and women's focus groups a colleague of the researcher also attended in order to take notes. In each case, permission was granted by the appropriate prison governor.

The updated research themes were presented to focus group participants on the graphic board and each issue was described in turn, inviting participants to share their own experiences of healthcare in prison. Participants were again invited to add to the graphic representation of their own experience and create a vision of what they would like to see happen in relation to each issue.

This study discovered that it had achieved credibility with group members because its initial call for participants had been placed in their own newsletter, *InsideTime*. A number spoke of their respect for this, and said that it had provided an opportunity for those who were wary of speaking out in front of others to get involved. Later, a number of women said they had also read and responded to the same article. These letters had not, however, been received.

Similar to Patenaude (2004), this research found it essential to gain the trust of prison governors by assuring them of the anonymity of the study. The personal recommendation of prison governors who had participated in the previous study *Options for Implementation of ICAS in Prisons* (Tabreham and Whiteside, 2005) was beneficial. This research was welcomed into a number of prisons on the strength of this. This was not the case everywhere, however. One healthcare manager said "we already know we've got problems in this place, the last thing we need is you coming in and telling us about them".

3.13.2 Male Focus Group

After an initial poor response to the invitation to participate letter which had been sent to governors, the male focus group was arranged. An officer with lead responsibility for prisoners' issues at a Strategic Health Authority (SHA) informed this research about a newly established Healthcare Forum at a men's category D prison. With the personal recommendation of the SHA officer, the healthcare governor at this establishment was approached and he agreed to allow the researcher to conduct the group. In this case too, the governor personally arranged to distribute participant information sheets to potential group participants.

Although the prison housed a range of prisoners on both short-term and life-sentences, it was, unlike the validation group, considered to be of lower risk of coercion or attack. The focus group was arranged in an informal setting within the healthcare centre without the need for prison officer observation. This prison was semi-open and participants were regularly permitted to leave the grounds. Conducting a focus group in this prison would, therefore, have placed the researcher and her companion note-taker and graphic artist at no greater risk than that posed to the external community.

When the meeting started, participants confirmed that they had received and understood the previously circulated information regarding the study. The participant instruction sheet was read aloud to group participants to ensure the purpose of the meeting was fully understood. This was done again in order to enable people to leave, if they felt the need to do so, before they formally became part of this study.

The graphic board was once more welcomed enthusiastically by group members who were keen to see what issues other participants had identified. The male focus group strongly endorsed their agreement with the issues identified to date, and added *assessment* to the emergent picture.

Figure 6

Assessment Graphic Icon

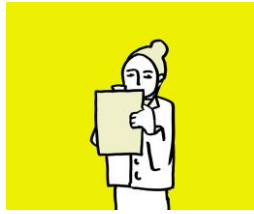


Figure 6 above showing the Assessment graphic icon identified by Male Focus Group member

A full transcript of the male focus group is included as Appendix H.

3.13.3 Women's Focus Group

The women's focus group took place in a women's semi-open prison at the personal invitation of the Governing Governor. In this case, also, the Governor, following a personal recommendation from another Governor welcomed the study and arranged for participation information to be circulated in advance. It was determined that the appropriate person to arrange the group was one of the imprisoned women.

No security risks were identified prior to the group, and a large informal room was provided for the use of the focus group. The graphic board depicting the themes identified to date was again displayed and a note-taker was also present.

Women focus group participants were dismissive about male prisoner's ability to care for one another, and argued that most care takes place within women's prisons. The group added a further six themes to those already identified, namely: *alcohol abuse, disability issues, mental health issues, prison hygiene, prison sub-cultures men and prison sub-cultures women.*

Table 9

Women's Focus Group Graphic Icons







Alcohol Abuse	Disability Issues	Mental Health	Prison Hygiene	Sub-Culture Women	Sub-Culture Men
					

Table 9 above showing the graphic icons identified by Women's Focus Group

A full transcript of the Women's Focus Group is included as Appendix I.

3.14 Phase Four; Participant and Stakeholder Interviews

3.14.1 Phase Four Objective

To gather imprisoned patients' and wider stakeholders' views about the research subject.

Phase Four involved:

- Inviting potential interviewees to participate through letters, phone calls, emails and personal recommendation,
- Circulating participant information.

3.14.2 Interviews Procedure

Qualitative interviews formed one of the most important sources of information. In open-ended and semi-structured interviews, participants were asked to comment about their experience of healthcare within the prison setting. They proposed solutions and provided insight into these events. They also corroborated evidence collected from other sources.

3.14.3 Semi-Structured Interview Young Person

As previously stated, access to a young offender institute was not possible and consequently, a semi-structured interview with a recently released young person was substituted. The selection criteria stated that the potential participant had been recently released from a young offender institute. It was also necessary that they had been incarcerated for a sufficient period, defined

as one year or above, to ensure they had had adequate experience of NHS prison healthcare.

A young man who matched the selection criteria consented to an interview on a one-to-one basis. The approach was made through an intermediary who knew both parties. Following the provision of participant information, the young person agreed to participate. An interview was arranged in a private location and, with his prior permission, the interview was to be recorded for later transcription. It was agreed that this tape would be offered to the participant for destruction following transcription. A fee of £100 was paid for the participant's time. This was the only monetary remuneration offered for this research.

As this was a one-to-one interview, suitable security arrangements were implemented. These comprised of:

- Logging visit into Carers Federation (the researcher's employing organisation) outreach visit system. This included notification of time expected back at office, location of proposed interview, emergency contact code to be used if required.
- Taking personal safety equipment (namely a fully charged mobile phone and personal alarm).
- Notifying colleague on duty to ensure researcher returned to the office at the expected time and agree arrangements in the event that this did not happen.

The interview was scheduled for approximately one hour and was semi-structured in nature. Questions were informed by the themes collected from participants to date. However, the semi-structured approach was deliberately chosen to allow the participant to discuss new issues as he considered appropriate. Prison *youth sub-culture* was the new theme identified in this interview.

Figure 7

Youth Sub-culture Graphic Icon

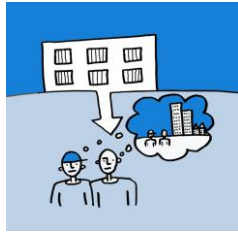


Figure 7 above showing the graphic icon identified by the young person interviewee

A full transcript of the semi-structured interview is included as Appendix J.

3.14.4 Open Interviews

Open-ended interviews were conducted with a number of key stakeholders to gain perspectives of prison healthcare. These included interviews with the following:

- Lord Ramsbotham
- Head of Healthcare - male prison
- Acting Head of Healthcare - female prison
- Imprisoned male carer

Interviews were arranged to take place in the participants' offices. With the exception of the Ramsbotham interview, a note-taker was also present on each occasion.

3.14.5 Lord Ramsbotham Interview

Lord Ramsbotham agreed to participate following an approach to his office at the House of Lords. Details of this interview are presented in section 1.5.1, as they are germane to the policy context for the transfer of prison healthcare to NHS responsibility.

3.14.6 Head of Healthcare Interview

A meeting with the Head of Healthcare in a men's local prison was arranged. The interviewee said that a small team of dedicated staff had made important improvements to patient care. They were currently overseeing the construction of new purpose-built patient facilities within the prison grounds.

The Head of Healthcare welcomed this study, and said it provided her with an opportunity to share her department's work. Following the interview, she provided a tour around the current health care facility, and highlighted the current building work. No additional themes were identified during this interview.

A full transcript of the Head of Healthcare Interview is included as Appendix K.

3.14.7 Acting Head of Healthcare

In contrast to the above, this interview took place in a women's prison in which healthcare was limited by poor facilities and gaps in service provision.

Primary care services were scarce, and the interviewee felt that many of the women were so unwell, that they should be housed in a nursing home instead.

One of the major issues raised during this interview was the perceived ambivalence which prison officers felt towards prison healthcare staff, depicted as the *staff conflict* graphic icon. A lack of prison *social care* was also identified as a theme in this interview.

These issues are represented in Figure 8 to follow.

Figure 8

Social Care and Staff Conflict Graphic Icons



Figure 8 above showing the social care and staff conflict graphic icons identified by the Acting Head of Healthcare Interviewee

A full transcript of the Acting Head of Healthcare Interview is included as Appendix L.

3.14.8 Imprisoned Carer Interview

Following publication of interim research material in the Health Service Journal (Tabreham, 2008), an opportunity arose to interview an imprisoned male carer. The prison Healthcare Governor arranged for the interview to take place in the participant's own cell. The Governor also ensured the male interviewee was fully informed and willing to take part. As this interview took place during the prison working day, time away from the work rota without loss of pay was also granted. Without this, he could not have afforded to participate as, he said, his reliance on his wage was so great.

A full transcript of the Carer Interview is included as Appendix M.

3.15 Phase Five: Discussion groups

3.15.1 Phase Five Objective

Discussion groups were not intended initially. Towards the end of the interview phase, however, the researcher was invited to discuss this study with a group of 22 males during a multi-agency visit to a male prison.

Phase Five involved:

- Obtaining Governor's permission
- Obtaining Department of Health's permission
- Security clearance

3.15.2 Discussion Group

The prisoners' Elders' Discussion Group held regular meetings to share issues of concern. Several participants chose to discuss their experience of healthcare with this research study during the visit. Of particular concern to this group was the bullying of older inmates and the large number of people with mental illness housed at the prison. It was reported that one man with mental ill health had recently committed suicide. Group participants were

extremely distressed about this, and felt that the prison had not taken the matter sufficiently seriously.

A full transcript of the Discussion Group is included as Appendix N.

3.15.3 Multi-Professional Stakeholder Group

As a result of this visit, the researcher was also invited to share her work with a multi-professional stakeholder group. The group had heard about the study, and members were interested to hear about the research material generated thus far. The graphic board was presented and discussed with the group who endorsed the content to date and shared their ideas for resolving some of the issues identified.

3.16 Validity

Respondent validation is considered to be one of the most robust validity tests for research, and involves taking the initial interpretations back to participants and ensuring that they agree with the developing analysis (Appleton, 1995; Avis, 1995; Yin, 1994; Yin, 2004). Thus, initial research themes were taken back to research participants through the validation group built into the early stages of this study. This is also a specific requirement of the Case Study approach adopted.

It was intended that, should validation group participants contradict initial results, further data would have been collected, analysed and discussed. The study would not have continued until the initial development analytic themes hypotheses had been fully validated by participants.

The Anti-Foundationalist ontological position meant that this research is not concerned with the quest for a *single objective truth*. Instead, the research matter will be explored from multiple participant subjective angles and sources. Meaning arising from later analysis and reflection will be considered in the final chapter of this thesis.

3.17 Sample Size Justification

This study intended to address the complex issues of meaning, values and understanding that are ascribed within the varied landscape of prison life. It was important to generate as much data as possible without the rigid framework imposed often by quantitative enquiry.

This study did not intend to bring forward arguments which could be considered *scientifically robust*, *statistically significant* or *objective*, but to describe the constructed reality of imprisoned patients' healthcare experience, allowing their *own voice* to be heard (as unconstrained as possible by the research process).

The Case Study methodology, therefore, dictated that the quality and detail of the dialogue with a breadth of participants was more important than a very large number of participants, as often required of quantitative methodology.

3.18 Conclusion

The research questions and purpose for the study arose out of the literature review and health policy interrogation. The complex issues pertaining to prisoner health, outlined in the summary of Chapter Two, enabled the creation of a suitable research framework.

The unique nature of this work, and *hard-to-reach* nature of the research population, indicated that the application of a qualitative Case Study approach would be particularly useful. As in many Cases, a multiplicity of factors impinge on imprisoned patients' experience, including health and social care provision, policy context, legislation, physical environments and underlying ill health needs. Together, these factors combine to create a complex landscape within which the promise of equitable healthcare should be delivered. This study will now explore whether it is possible to achieve this for this chronically sick and disadvantaged group of patients.

CHAPTER FOUR: DATA ANALYSIS

Any researcher who wishes to become proficient at doing qualitative analysis must learn to code well and easily. The excellence of the research rests in part on the excellence of the coding

Anslem L. Strauss (1987, p. 27).

4.1 Introduction

This chapter focuses on data analysis and presents the results generated via the participant data collected in the field, alongside the analysis processes undertaken. It is worth noting that the differing forms of data collected are analysed as one body of data. This means that focus group data are not considered distinct from interview data.

Imprisoned patients' experience arising from this study is important and influential for the field of NHS prison healthcare, and is presented and debated in Chapter Five in full. Additionally, transcripts and other data collected are included in the appendices. The inclusion of these data is intended to aptly disseminate the voice of this under-researched population and, thus, contribute to the positive development of their healthcare.

This chapter presents the Case Study model showing the multiple and varied data sources used. This is followed by consideration of the implications of researcher bias. Fieldwork data will then be presented in the following order:

1. Prison Category Breakdown
2. Participant Breakdown
3. Participant Gender
4. Participant Ethnic Status
5. Participant Age Profile

The presentation of data relating to participant's age will be followed by a discussion of the framework applied to construct the research themes. This chapter will then conclude with a table of results, presenting the research themes identified, namely:

6. Initial Research Themes
7. Research Context Clusters
8. Full Research Themes Table of Results showing:
 - a. Sub-categories
 - b. Research Themes
 - c. Key Themes
 - d. Overarching Themes

4.2 The Case

It is recognised that, in order to achieve the “polyhedron of intelligibility” described by Foucault (1981, p.6), effective case studies demand multiple and varied data sources via exploring prisoners' experience of healthcare and its equitability. Accordingly, this research fulfils this requirement.

In order to construct a three-dimensional picture of the research phenomena demanded by Yin (1994), direct contact with research participants was considered essential. A model showing the multiple and varied data sources within the case is presented in Figure 9 overleaf.

Figure 9

'The Case' Showing the Multiple and Varied Data Sources Used

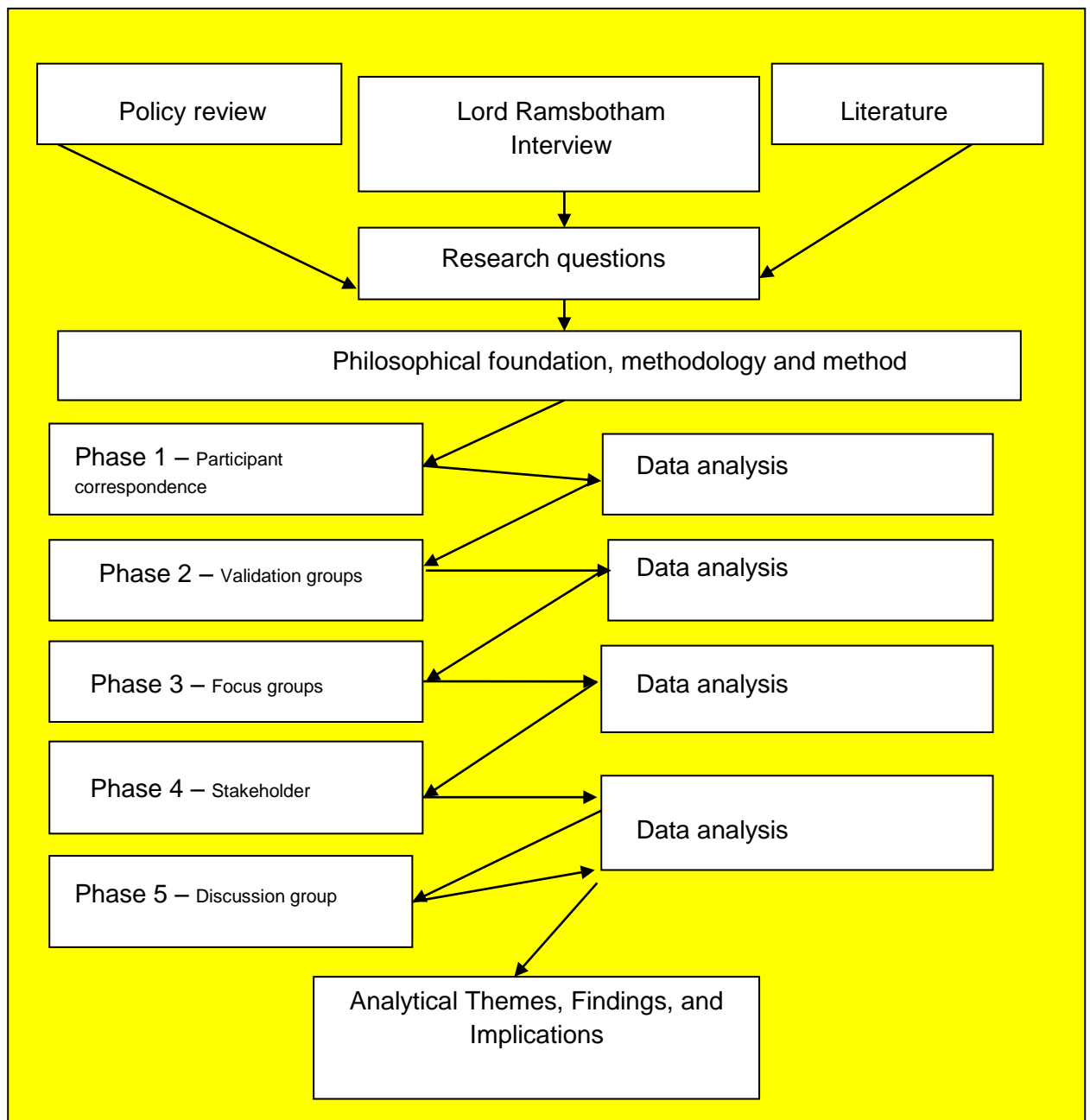


Figure 9 above showing data sources used for all phases of this study.

It is important to acknowledge that access to the multiple data sources, for the most part, required direct contact with participants. This would not have been possible without the generosity and support of several committed prison governors. This assistance, as previously stated, resulted from their prior involvement in the researcher's preceding work. Therefore, although valuable, this involvement also raises a number of issues in relation to researcher's bias.

4.3 Implications of Researcher Bias

It is argued that the misrepresentation of ideas, facts or people can lead to research findings that are untrustworthy (Holloway, 2008; Polit and Hungler, 1996). *Bias* is a term which is seldom used in qualitative studies. Here, the explicit preconceptions and assumptions of the researcher are seen as a distinct resource, rather than a difficulty (Yin, 2004).

It is important, therefore, that life experience and values are acknowledged in order to avoid the undue influencing of this study. This is particularly relevant where objectivity is sought (Holloway and Wheeler, 1996). This was not, however, a prime concern here. Rather, the focus of this work is the participants' subjective experiences.

O'Connell Davidson and Layder (1994, p. 169) asserted that, whilst conducting qualitative analysis:

[...] there is a strong possibility the researcher will interpret what is going on from the point of view of his or her own cultural and social position. Bias may thus occur through the imposition of preconceptions and stereotypical assumptions.

There are a number of procedures designed to reduce the potential for bias. These include research tools most frequently used in quantitative research, such as blind trials and random selection of participants. Replicability was not a requirement of this study and these procedures were, therefore, considered unsuitable.

Yin (1994) advocates researchers using clues in the field to construct a response. Via this approach, rather than being directed to a specific theory/answer as a result of research hypotheses, the evidence and interpretations from the Case Study drive the generation of theory via the inductive approach employed (Pandit, 1996). The construction of meaningful research conclusions, exploring and analysing the nature of the fieldwork sites as the study and data collection processes continue is, therefore, essential to this process.

The researcher's interest in prisoner health stems from an options report commissioned by John Reid, the then Secretary of State for Health (Tabreham and Whiteside, 2005). The study demanded a national sample of data from prison governors and prominent others charged with prisoner welfare. In 2004, numerous prison governors attended discussion groups and were very supportive of the research.

The final report raised a number of significant questions regarding the health experience of imprisoned patients and their ability to bring forward NHS complaints in particular. Examination of the literature available at that time indicated that prisoners were a difficult community to access for research and, as a result, many studies were conducted externally and were small-scale or epidemiologically specific only. Mindful that the transfer of prison healthcare was an attempt at system-wide change at a national level, the researcher wished to explore any difference in the experience of imprisoned patients both pre-and post-transfer.

Having met previously with a small number of women prisoners in the aforementioned study, the researcher had also been interested to explore and analyse their difficult life journey and the problems they met when attempting to access health services. These powerful participant accounts challenged several previously held underlying prejudices and assumptions regarding the prison population.

The researcher, therefore, acknowledges her academic interest regarding imprisoned patients' health experience. Reflecting on the requirement of Case Study to use multiple and varied data sources, previously described, she felt that this would contribute towards countering any underlying research bias. Certainly, it could alternatively be posited that the number of fieldwork sites and volume of data collected do not alter an understanding that there is an interest in this area, or, indeed, that researcher bias can ever be entirely eliminated.

Examination of the literature clearly indicated that research access to prison establishments would be problematic (Patenaude, 2004). Prison governors were, and still remain, the ultimate authority in granting permission for anyone

wishing to enter their premises. As the response from the initial letter requesting access in Phase One proved disappointing, the prison governors worked with previously were contacted again. Thus, a number of prison governors welcomed this research and even advocated the study amongst colleagues. Notably, without this support, the Women's Focus Group would not have taken place and this research would have been weakened as a result.

The possibility that this study has been influenced by the willingness of this small group of governors must be acknowledged. Further, Perspectivism would propose that those who did not take part may have prevented other research themes from being identified. For instance, Nietzsche would argue that all perspectives are inherently value-based, and we interpret the world from our own unique point of view (Hollingdale, 1990). In response to this small and convenient sample of prisons, prisoners throughout England were invited to participate personally. 67 participated from ten divergent forms of prison establishment ranging from high-secure to Category D. These 67 responses lead to the 14 initial themes identified in Phase One.

On reflection, those governors that offered their establishments as fieldwork sites had not done so to demonstrate first class healthcare facilities. With the exception of one prison, all other establishments visited were experiencing severe overcrowding, decreasing capacity, and increasingly inadequate resources, described by one as "the system running hot". To illustrate this, during one fieldwork trip, the Governor was confronted by an angry prisoner who was shouting and was visibly hostile. Effortlessly, the Governor shepherded the distressed man back into his cell which he then locked, promising to return to hear his problems later. This incident was dealt with quietly and calmly and had the appearance of a regular feature in the Governor's life.

Bias within this study is, therefore, inherent as it represents a self-selecting convenience sample. However, the qualitative approach adopted did not require a representative depiction of patients' experience in English prisons. Instead a wide variety of participant views were sought to illuminate the experience of those taking part and the multiple opportunities provided for this

input, it was hoped, went some way to mitigate bias where it exists. Further, during the fieldwork and analysis phases of this study, interpretations are considered in relation to its alignment with the data. Thus, that these reflect the data and not the researcher's own expectations or biases.

4.4 Data

Table 10 demonstrates the prison categories in which participants resided. The table exemplifies the diverse range of prison estate represented.

Table 10
Prison Category Clusters Correspondent Participants

Phase	1	2	3	4	5
Category (below)					
Category B (restricted status)	1				
High Security	14	22			22
Local Female	2		16		
Local Male	21				
Males Category B	6			1	
Males Category C	14		4		
Males Category D	2				
Misc.	3				
Young Offender Institute Open	1				

Young Offender Institute Closed	3			1	
Total Participants	67	22	20	2	22

N	=	133	Total responses
N	=	109	Male prisoners
N	=	3	Transgender prisoners
N	=	21	Female prisoners

These results show that males were overwhelmingly represented in Phase One of this study.

Despite the rise in female imprisonment, up 33% in the last decade, the total figure for women stood at 4,230 on the 6th of August, 2010 (Ministry of Justice, 2010). In contrast, for males this figure was 80,900.

This represented an overall percentage of 5.04%, making the number of female participants over-represented in this phase of the study at 7.46%.

Figure 10

Prisons Categories Represented in this Study

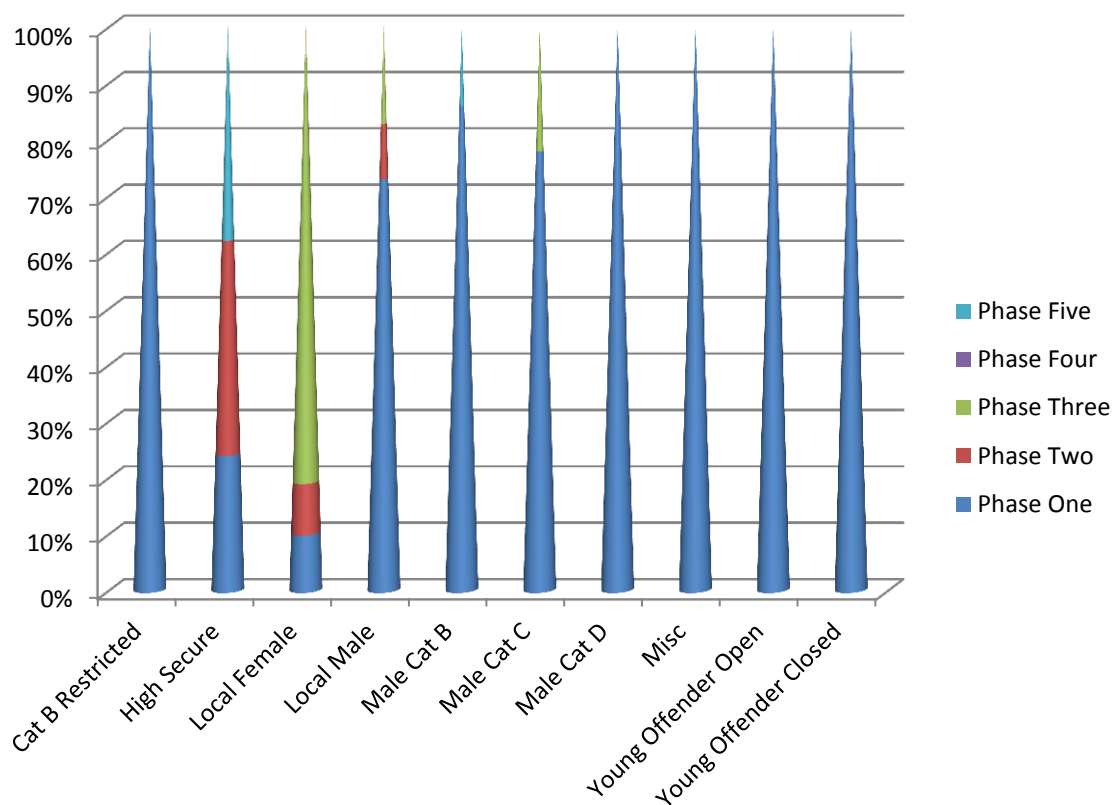


Figure 10 above shows the prison categories represented in Phase One of this study for Table 10.

The next table demonstrates the participant breakdown for all phases of this study. There were 109 male participants, 3 male-to-female transgender participants and 21 female. Women represented 15.79% of participants overall, showing that their rate of over-representation increased as this study progressed. Transgender women represented 2.26%. However, no figures exist detailing the number of people of this gender in English prisons. Men represented 81.95%, making them slightly under-represented.

Accordingly, this study must consider the ramifications of this gender-imbalanced sample in the latter phases of this research. Arguably, it could be inferred that the research themes arising from focus group discussions may somewhat reflect the experiences and healthcare desires of female prisoners more than male prisoners.

Table 11**Total Participant Table**

This table presents the participant data across all phases of this study. It includes prisoner participants and other stakeholders who were interviewed. Stakeholders are defined as non-prisoner participants.

Phase One
Open interview Lord Ramsbotham N = 1 67 letters received from imprisoned patients (see table above for prison category breakdown) N = 59 male participants N = 3 transgender participants N = 5 female participants
Phase Two
Validation group N = 22 male participants
Phase Three
Male Focus Group N = 4 male participants
Female Focus Group N = 16 female participants
Phase Four
Semi-structured interview with recently released young offender N = 1 male participant
Open interview head of prison healthcare N = 1 female participant
Open interview prison nurse N = 1 female participant
One-to-one open-ended interview with prison carer N = 1 male participant
Phase Five
Discussion group N = 22 male participants

Multi-stakeholder meeting
N = 13 male participants
N = 2 female participants

4.4.2 Participant Gender

Figure 11

Prisoner Gender Categories

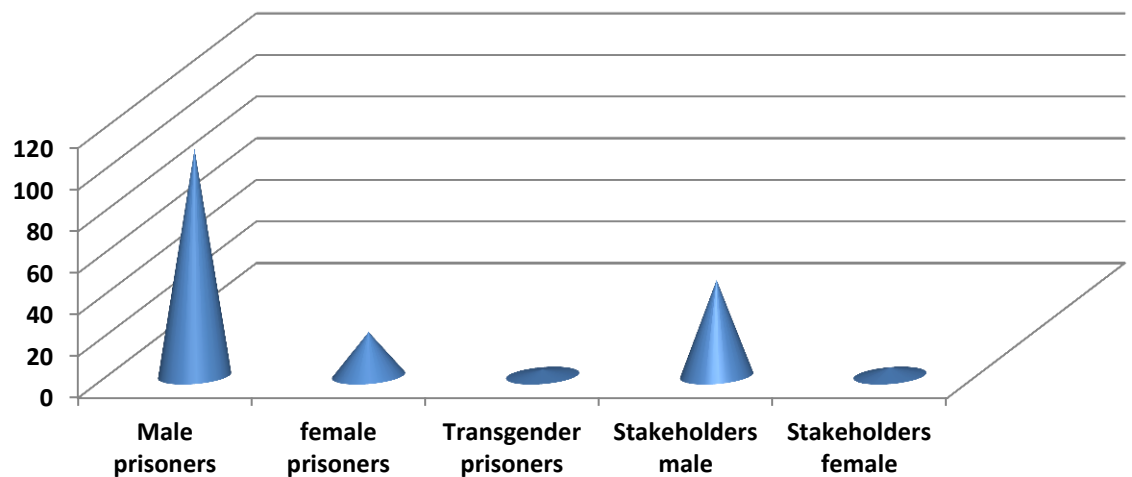


Figure 11 above showing the breakdown of the prisoner gender categories for Phases Two to Five of this study.

4.4.3 Participant Ethnic Status

Phase One was a self-selecting sample and only seven men disclosed their ethnicity within their letters. These individuals were Black or Asian.

Within the validation group, focus groups, interview and discussion group, 15 men and 4 women were visibly from Minority Ethnic Communities. This figure is not reliable, however, as it is based on observation in the field. It does not, therefore, include people from white Minority Ethnic communities.

Figure 12
Participant Ethnicity

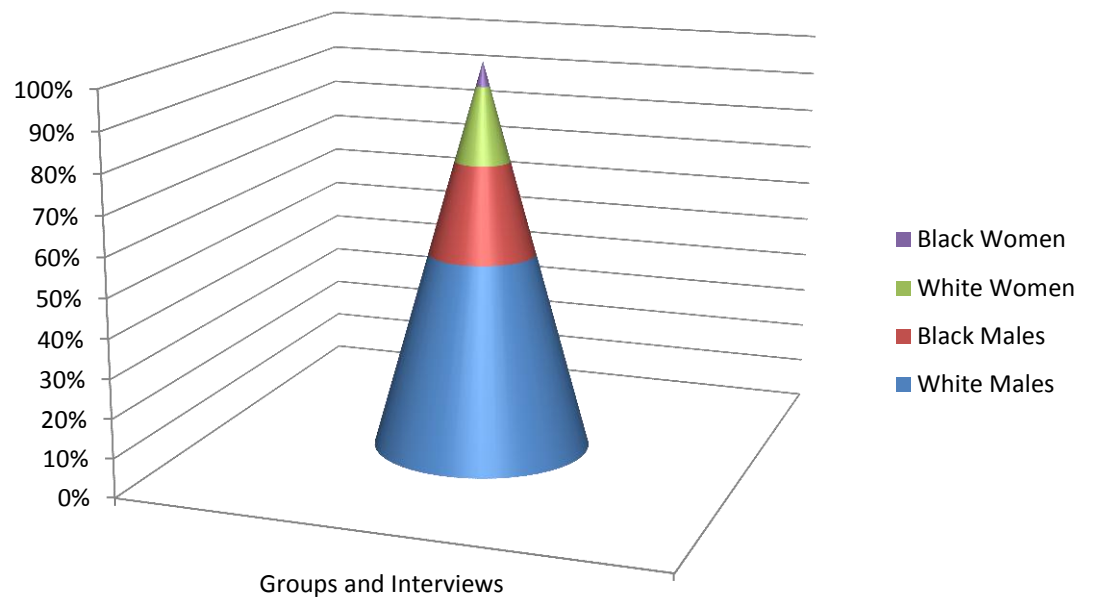


Figure 12 above showing ethnicity data for Phases Two to Five of this study.

4.4.4 Participant Age Profile

Similarly, age data was not collected for participants in Phase One. It was again estimated for participants in the validation group, focus groups, interviews and discussion groups.

Figure 13
Participant Age

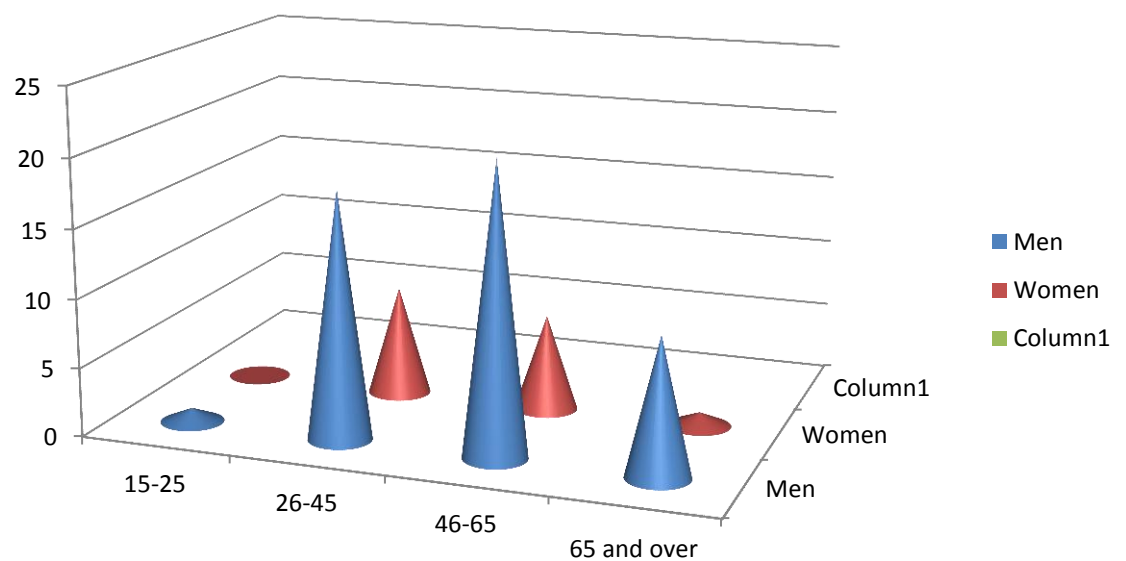


Figure 13 above showing participant age profile

4.5 Conceptual Analysis

This section of the thesis demonstrates the analysis undertaken.

4.5.1 Application of Colazzi's (1978) Framework

This framework was applied in the following manner in order to generate key research themes as important to the study's participants and the notion of equity in healthcare.

Colazzi Step 1

Read all the subjects' descriptions, conventionally termed protocols, in order to acquire a feeling for them, 'making sense' of them.

Phase One letters received from participants were transcribed verbatim. Repetitive reading of the texts was conducted in order to *acquire a feeling* for the contents. However, as the data came in the form of letters, it was not possible to ascertain the individual participant's emotions, desires, intentions or psychological mood at time of writing, as this cannot be usually understood from transcription notes alone.

At this stage, initial thoughts were shared with academic colleagues regarding the material. The data was complex and spread over 190 A4 pages of transcribed notes. The large volume of material generated made it difficult to identify key themes at this stage. Instead, as is usual with qualitative studies, numerous first-draft codes were attached to the data to begin analysis.

Colazzi Step 2

Return to each protocol and extract from them phrases or sentences known as significant statements.

Several letters contained the same, or similar, statements regarding prisoner's healthcare experience. The statements identified as being of particular importance for participants were highlighted independently in marker pen by the researcher and an academic colleague. This process was complex and time consuming taking a number of weeks to complete. The researcher, academic and non-academic colleagues compared their initial thoughts and discussed areas of consensus and difference amongst the early codes posited.

Colazzi Step 3

Spell out the meaning of each significant statement, known as formulating meanings.

After reading the letter transcriptions several times, certain significant statements were found to be common, leading to Colazzi's (1978) creative insight stage. This step in the analysis process requires interpretation. From what interviewees have said, meaning must be formulated from the researcher's opinion about what participants actually meant, or intended. Researchers are required, therefore, to have an awareness of the formulated meaning. These should not be severed from the original protocols and that accurate interpretations are incrementally uncovered and discovered.

This aspect of Colazzi's framework, phenomenological in nature, was not an ideal alignment with the methodological approach adopted by this study. Therefore, this step was only loosely adhered to. Thus, the material

analysed was not severed from the text, and meaning was derived from what was said.

Colazzi Step 4

Organise the formulated meaning into clusters of themes.

In order to analyse the data further, the formulated meanings were organised into thematic clusters. This was a complicated task which again took several weeks. After much discussion, the transcribed material was magnified to size 24 font and the highlighted passages were printed, cut out and spread across the floor of a large open plan office. Similar statements were then clustered together and finally arranged in rows across the office corridor. A title sheet, which had the appearance of closest alignment or similar meaning with the data, was placed at the head of each row.

Following the identification of an initial 14 themes, three colleagues (not involved in the study) were asked to walk through the rows and assess whether the clusters made sense. No identifiable data was included here, thus upholding participants' confidentiality and anonymity. A photograph of this process is shown in figure 14.

Figure 14
Initial Research Themes



Figure 14 above showing identification of initial research themes

One of the major difficulties at this stage was prisoners'/participants' poor standard of literacy. Some words could not be deciphered, and this may have affected the accuracy of the interpreted meaning. Other letters had long complex paragraphs which contained many issues, some exploring a number of themes simultaneously.

Table 12**Initial 14 Themes**

This table presents the original data identified by Phase One participants who wrote to the study.

Themes	Topic
11	Access to specialists
13	Complaints
5	Dispensary opening times
6	Drug misuse
4	External support
3	Healthcare facilities
8	Healthcare staff
7	Medical records-assessment
2	Medication
14	Prison regulations
9	Privacy
10	Treatment
1	Variation in healthcare provision
12	Waiting times

At this stage, transcription had the formulated meaning categorised using N6 and N7 software. A data coding tree was created, and each of the 14 themes in Table 12 above was coded as *nodes* in the database. Sub-categories of each of these were then coded and included under the headings, as appropriate. The data was also coded by prison category and the context of each letter.

The following screenshot is an example of a data tree, labelled node and the sub-issues raised within a theme:

Nodes

- Free Nodes
- Tree Nodes
- Cases
- Relationships
- Matrices
- Search Folders
- All Nodes

Sources

Nodes

Sets

Queries

Models

Links

260 Items

Tree Nodes

Name	Sources	References	Created	Modified
Access to prisoners	0	0	12/02/2008 08:4	12/02/2008 08:4
Research permission denied	2	2	12/02/2008 08:4	12/02/2008 08:4
Research permission welcomed	2	2	12/02/2008 08:4	12/02/2008 08:4
Access to specialists	0	0	02/03/2007 15:2	23/03/2007 11:3
Access to external appointments	4	9	02/03/2007 15:5	11/02/2008 15:1
daily cancer treatment denied	1	1	06/06/2007 19:3	10/02/2008 10:2
Long waiting lists for external ap	1	1	02/03/2007 15:5	10/02/2008 10:2
Refusal of treatment by specialist	2	3	02/03/2007 15:5	10/02/2008 17:2
Refusal to facilitate hospital treat	4	6	02/03/2007 15:5	11/02/2008 15:1
Care post-release	2	6	10/02/2008 11:4	11/02/2008 16:1
Carers in prison	5	10	10/02/2008 12:0	11/02/2008 15:5
Case Data	0	0	13/04/2007 12:3	13/04/2007 13:2
Category	0	0	13/04/2007 12:3	13/04/2007 12:3
Cat B Men	2	8	13/04/2007 12:4	10/02/2008 17:5
Cat B Restricted	1	1	13/04/2007 12:4	10/02/2008 10:2
Cat B Women	0	0	13/04/2007 12:4	13/04/2007 12:4

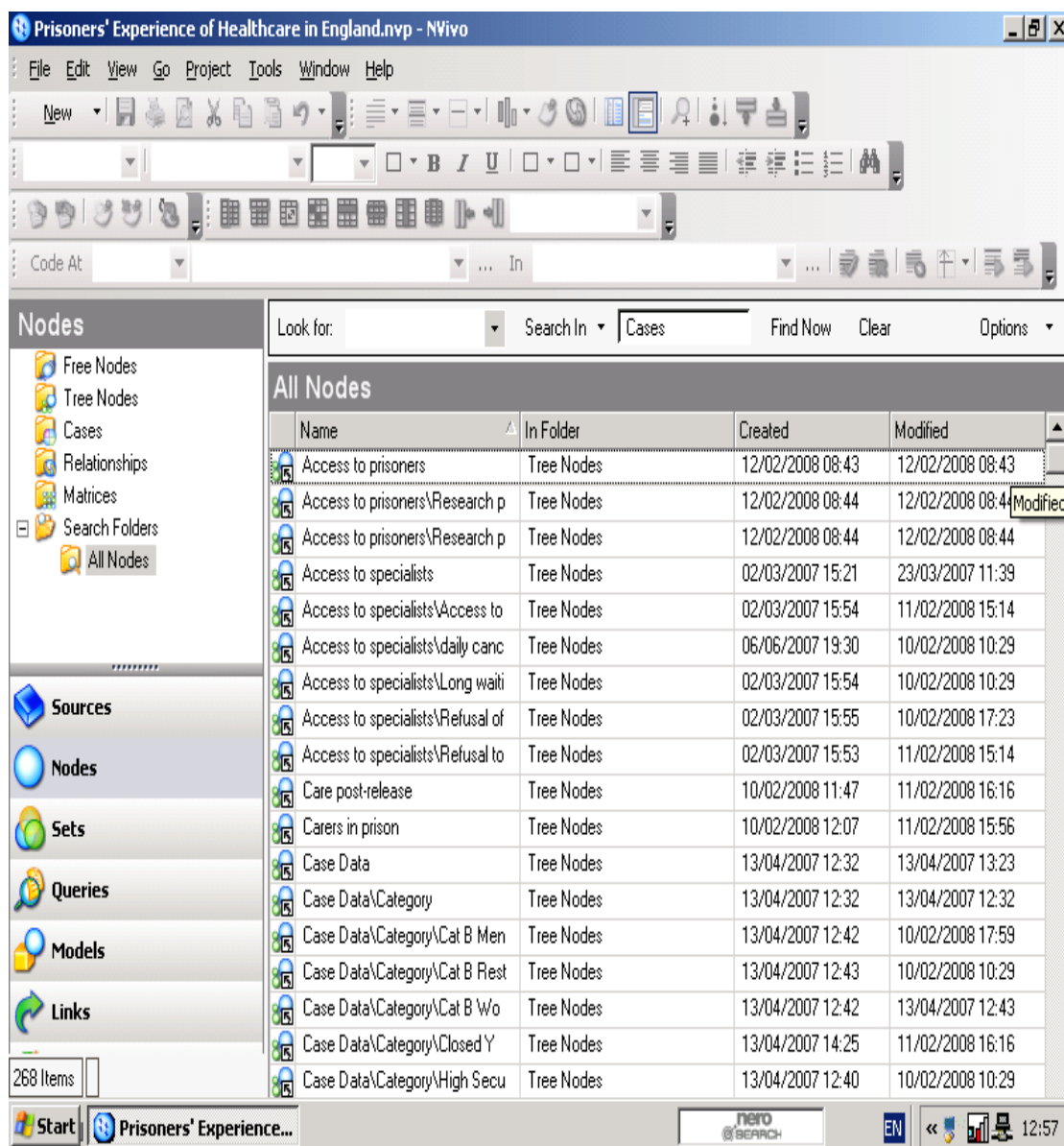
Table 13

Table 13 showing context clusters.

Context Clusters

Number	Context of letter
16	Chronically sick and disabled prisoner
12	Complaints
26	Detoxification
8	Difficult to access external care
27	Dirty facilities
20	Equipment needed within the prison
28	Food
3	General
10	Healthcare staff
30	Improved treatment
9	Inability to treat within prison
4	Injury external
14	Lack of information
5	Lack of records
25	Language barrier
21	Legal
6	Medication
13	Mental health
24	Non-NHS treatment
22	Poor literacy
11	Poor treatment within the prison
17	Prejudice and discrimination against prisoner
23	Prison regulations
19	Privacy
15	Racism
18	Self-help and support
1	Serious injury gained outside of prison
2	Specialist care
29	Variation in treatment
7	Waiting times

Screen shot below showing a case search:



Once the clusters had been formulated the next stage in Colaizzi's framework was followed:

Colaizzi Step 4a

Refer these clusters of themes back to the original protocols in order to validate them.

This was achieved by asking whether there was anything contained in the original letters that was not accounted for in the themes identified and, similarly, whether there was anything in the clusters which was also not accounted for in the original letters. The initial research themes would not be validated if there was any evidence of other material not present in the

original protocol. The themes were referred back to the protocols to validate them by cross-checking. This detailed check proved successful in that neither the clusters, nor the protocol, were found to be unsupported by the research data.

Colazzi Step 4b

At this point discrepancies may be noted among and/or between the various clusters. Researchers must refuse the temptation of ignoring data or themes, which do not fit. Within any research study some themes may flatly oppose or appear unrelated to others. Results so far are integrated into an exhaustive description of the investigated topic.

In light of the emergent cluster of themes (1-14) derived from the verbal dialogue during the data gathering processes, each theme was considered at length. Excerpts were taken from the interview transcriptions in order to illuminate the forthcoming validation group, semi-structured interviews and focus groups.

This process continued throughout the entire study, and the number of themes eventually identified stood at 24.

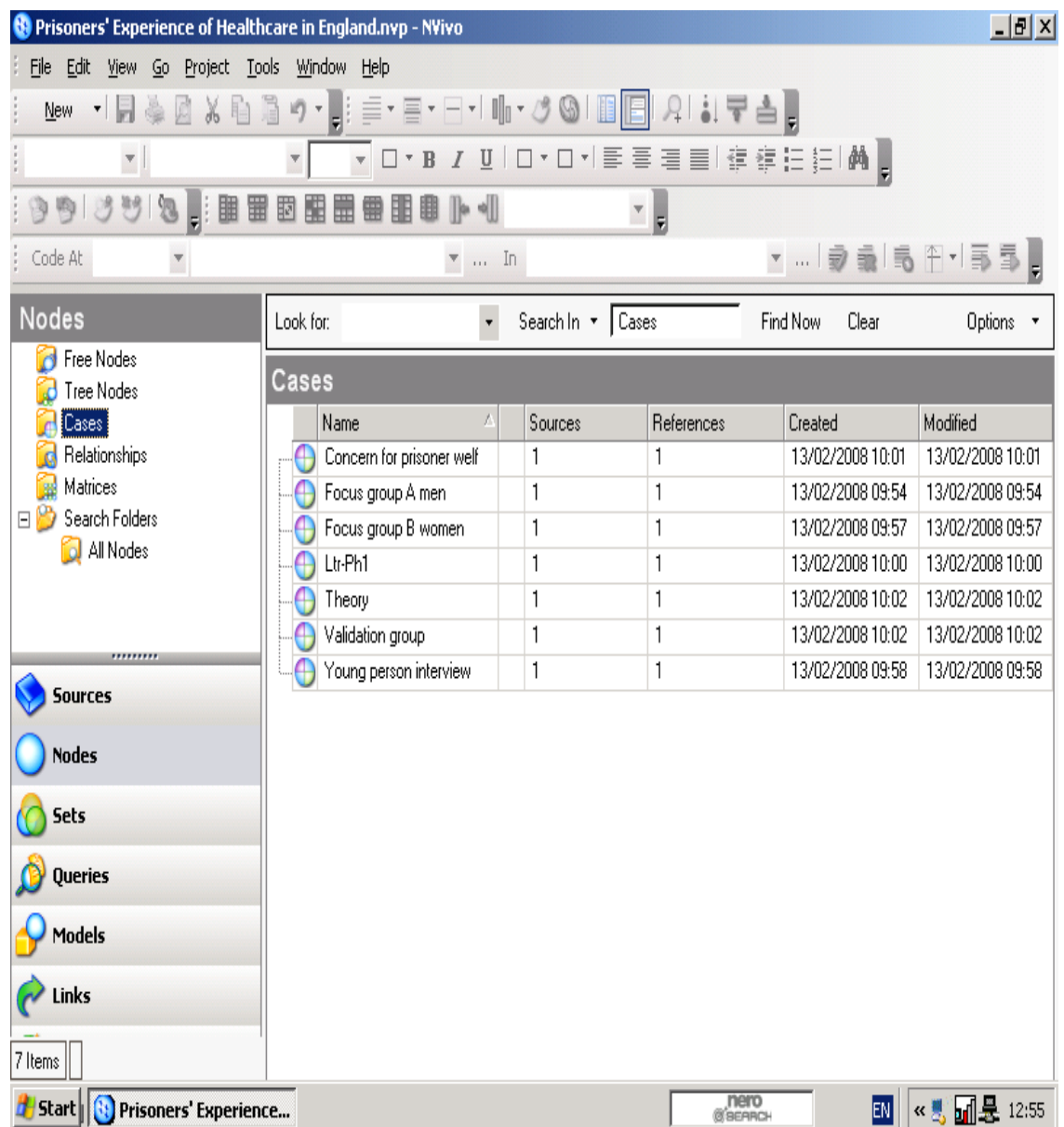
4.7 Data Software Management

This section shows a selection of screen shots showing the N6 and N7 database which was used to aid the analysis of the data for this study. The first screen shot shows the cases generated. The second screen shot demonstrates the categories of coded documents within the project database and the third screen shot is a sample of context issues. A further explanation of the content of the screen shots featured is also included as Appendix P.

A case, in this context, is a category of information. Categories included:

- focus group men
- focus group women
- literature review
- theory
- validation group
- young person interview

Screen shot showing cases:

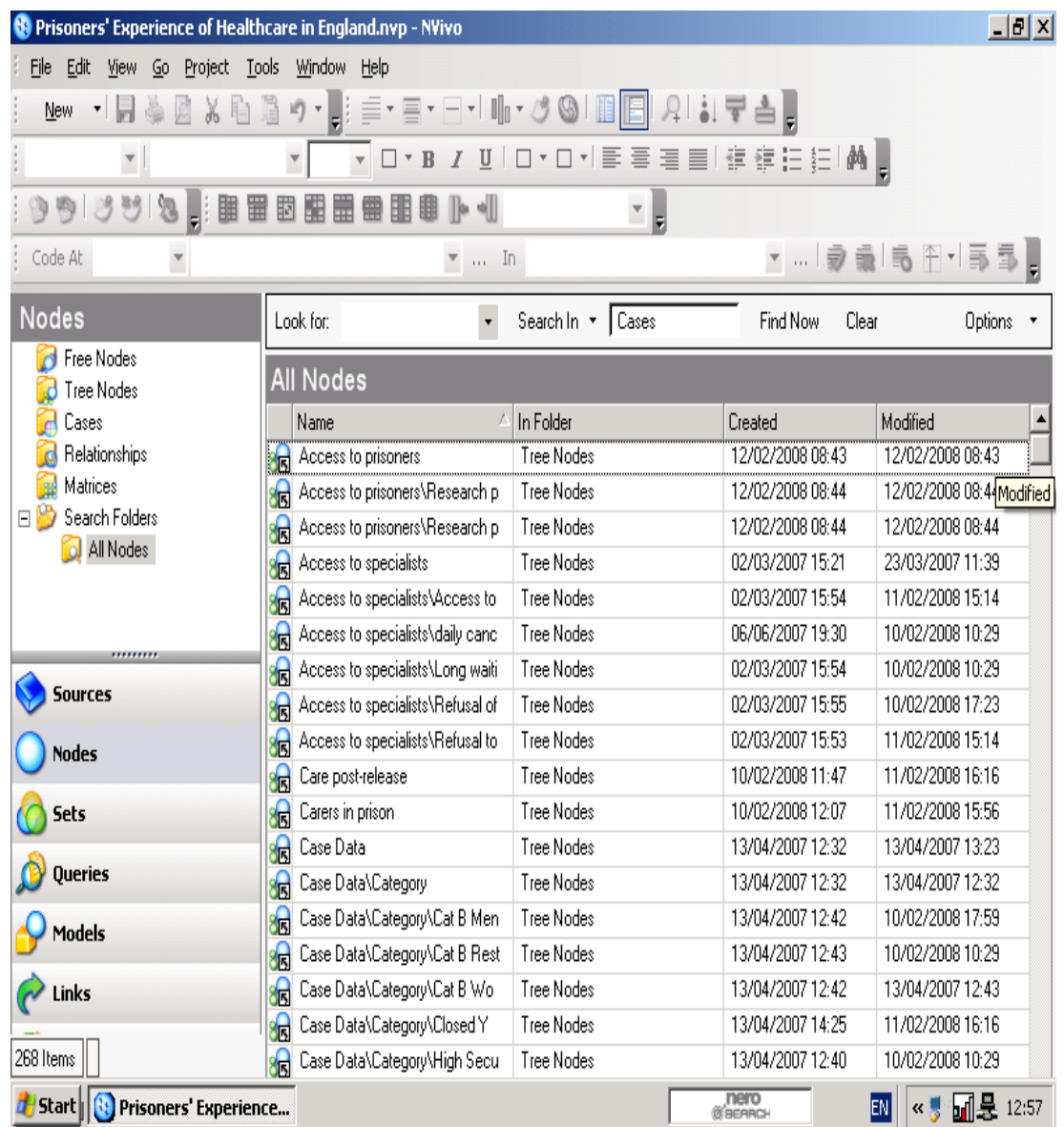


The screenshot shows the NVivo software interface. The title bar reads "Prisoners' Experience of Healthcare in England.nvp - NVivo". The menu bar includes File, Edit, View, Go, Project, Tools, Window, and Help. The toolbar contains various icons for file operations and analysis. The left sidebar shows a tree view of nodes, with "Cases" selected. Below the sidebar, there are buttons for Sources, Nodes, Sets, Queries, Models, and Links. The main area displays a table of cases with the following data:

Name	Sources	References	Created	Modified
Concern for prisoner welf	1	1	13/02/2008 10:01	13/02/2008 10:01
Focus group A men	1	1	13/02/2008 09:54	13/02/2008 09:54
Focus group B women	1	1	13/02/2008 09:57	13/02/2008 09:57
Ltr-Ph1	1	1	13/02/2008 10:00	13/02/2008 10:00
Theory	1	1	13/02/2008 10:02	13/02/2008 10:02
Validation group	1	1	13/02/2008 10:02	13/02/2008 10:02
Young person interview	1	1	13/02/2008 09:58	13/02/2008 09:58

The bottom of the screen shows the Windows taskbar with the Start button, the application name "Prisoners' Experience...", and the system clock showing 12:55.

By coding data against each distinct area, relationships between the data and any trends or contradictions emerged. At the point at which the study's data input was complete, this would be used to support the intent of this research to generate final themes, as well as novel theory and findings.



This element of the data package enabled links and themes. This proved to be particularly valuable, and greatly assisted the interpretation of a large quantity of material. The fourth screen shot provides an example of a node and shows the relevant sub-issues coded against it. A Word document showing expanded node tables for 1-14 is also provided for further information.

4.8 Data Analysis Procedure

After researching a variety of qualitative research support packages, QSR N6 was selected (although later data were analysed using the updated N7 version). This was earlier known as NUD*IST (Non-numerical Unstructured Data Indexing Searching and Theorising). NUD*IST represents a computer software toolkit based on coding text documents, interview transcripts and field notes, and then analysing and exploring that coding.

QSR N6 is capable of supporting a wide range of methodological or philosophical approaches to research, whether that is ethnography, grounded theory, phenomenology, or others, making it a flexible tool for qualitative social scientists. N6 is designed to work with a wide range of data and is, therefore, capable of handling individual interviews, focus groups, structured qualitative questionnaires, or conversation and journals. Thus, this software package is suitable for a textually rich study of this kind.

Data was initially transcribed from tape recording (in the case of the young offender fieldwork session), and from field notes taken by note-takers at the validation group, focus group, discussion group and interviews. These were stored in the study's database under the appropriate headings in Microsoft Word format for later coding using QSR N6 and N7 software.

The N6 package provides a node (thematic clusters/themes) search function able to operate on two complementary sets of data simultaneously. As the fieldwork for this study progressed, a project node structure was developed to organise and manage emergent research themes. This was informed and greatly assisted by the initial analysis generated through the application of Colazzi's Seven Step procedure, as previously explained.

A project database was created to hold the material to be coded as generated in the fieldwork phase of this study. The Text Search and Node Search functions proved valuable, thus allowing the large quantity of material generated to be interrogated easily. Continued data comparison built new nodes incrementally, building theory throughout each phase of this study.

4.9 Category Saturation

4.9.1 Open Coding

This study design included the devotion of considerable time for data analysis and for coding the material thoroughly and rigorously. Data coded at the node included: age, gender, demographics for interviewees, prisoner and context (e.g. trusting doctors).

Although N6 and N7 managed and assisted locating the topics to code and identifying connections between research themes, the analyst made the important and influential coding decisions.

Category saturation was considered to be complete when no new *properties, dimensions, conditions, actions/interactions, or consequences* (Strauss and Corbin, 1998, p. 136) were identified.

Table 14
Research Themes Identified by Participant Cohorts

Identified By	Theme
Phase One correspondents	Access to specialists, complaints, dispensary opening times, drug misuse, external support, healthcare facilities, healthcare staff, medical records–assessment, medication, prison regulations, privacy, treatment, variation in healthcare provision, waiting times
Validation Group	Carers
Male Focus Group	Assessment, Illegal drugs
Female Focus Group	Alcohol abuse, disability issues, mental health issues, prison adult sub-cultures, prison hygiene
Young Person	Prison staff, prison youth sub-culture
Acting Head of Healthcare	Social care

4.9.2 Theoretical Saturation

Faithful to the qualitative inductive facet of a grounded theory approach to research analysis, the abductive reasoning applied to this analysis process enabled the research phenomena to surface. Three Key Themes emerged:

1. Beliefs, Attitudes and Behaviour

This cluster of empirical data related to many of the cultural aspects of prisoners' existence.

2. Service Commissioning, Delivery and Constraints

Here, an extensive amount of research material related to constraints to the purchase and delivery of services for imprisoned patients.

Environmental factors impacting effective service delivery is also included.

3. Patients Health and Patient Outcomes

The underlying ill health of this population and key factors negatively impacting improvement in health and wellbeing are featured here.

An independent qualitative researcher explored the validity of the aforementioned Key Themes identified, via selecting a random sample within each category from the N6/N7 database for examination. Data coding, memos, research notes, category and context coding were reviewed for each of these for analytic accuracy and saturation alongside any divergent participants' experiences, opinions and perceptions.

4.10 Key Themes

At this stage of analysis, the 24 research themes identified were explored to find linkages and connections between the categories and sub-categories. For Grounded Theory, Glaser and Strauss (1967) argue that there are prepositions indicating generalised relationships between one category and other discrete categories. Through the continued process of coding, again utilising Collazi's method, the relationship between sub-themes, themes, Key Themes and the overarching theme was identified.

4.11 Building a Grounded Theory

To summarise the analytic building of a grounded theory thus far, five distinct phases were operationalised: research design, initial data collection, thematic analysis, healthcare policy comparison and wider healthcare literature comparison. Under these broad analytic headings, Colazzi's (1978) Seven Procedural Steps Method was used.

These interrelated phases were considered against research quality criteria:

1. Construct validity – through the clear application of operational procedures,
2. Internal validity – saturation of the data themes and context leading to clearly identifiable relationships/conditions,
3. External validity – through the generation of theory, specific to the domain of Case Study, without the intention of wider applicability,
4. Reliability – the subjective nature of qualitative research means that others replicating this study from the data supplied will be unlikely to achieve exactly the same *results*.

Reliability, taken here to mean replicability, was not, therefore, considered valuable research criteria for this qualitative interpretive study. Figure 15 shows the interrelated phases of theory building:

Figure 15

Grounded Theory Step 1

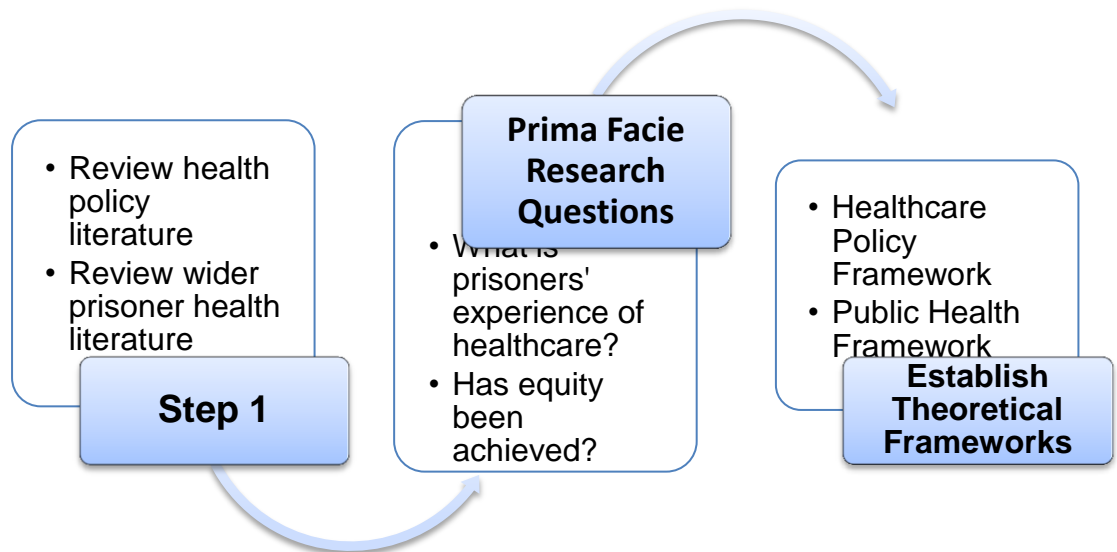


Figure 15 shows the initial step in theory generation

The initial grounded analysis of healthcare policy literature generated this study's initial theoretical framework. Identified in the model above, initial data exploration led to the choice of Ham's (2004) healthcare policy development theory. The author posited that this contained three key ingredients required for successful healthcare policy development and implementation. These were:

1. Recognition of pertinent health-related issues for prisoners
2. Dynamic process driven by individuals/groups with the power to influence
3. Actions of those with the power to determine policy

Within this theoretical framework, the healthcare policy literature has been grounded. Arising from this, the selection of this study's second theoretical framework was selected, as it provided an excellent conceptual alignment with the focus of this research. The wider relevant prisoner healthcare literature was critically appraised under the Policy's four sub-categories, and the implications for prisoners' health was conceptualised.

The four sub-categories were:

1. health promotion
2. health education
3. disease prevention
4. healthy settings

Following this initial first step, the process of data collection for the generation of theory according to the principle of theoretical sampling began. Strauss and Corbin (1990) assert that, unlike quantitative investigations, theoretical sampling must emerge as the study evolves.

Figure 16

Grounded Theory Step 2

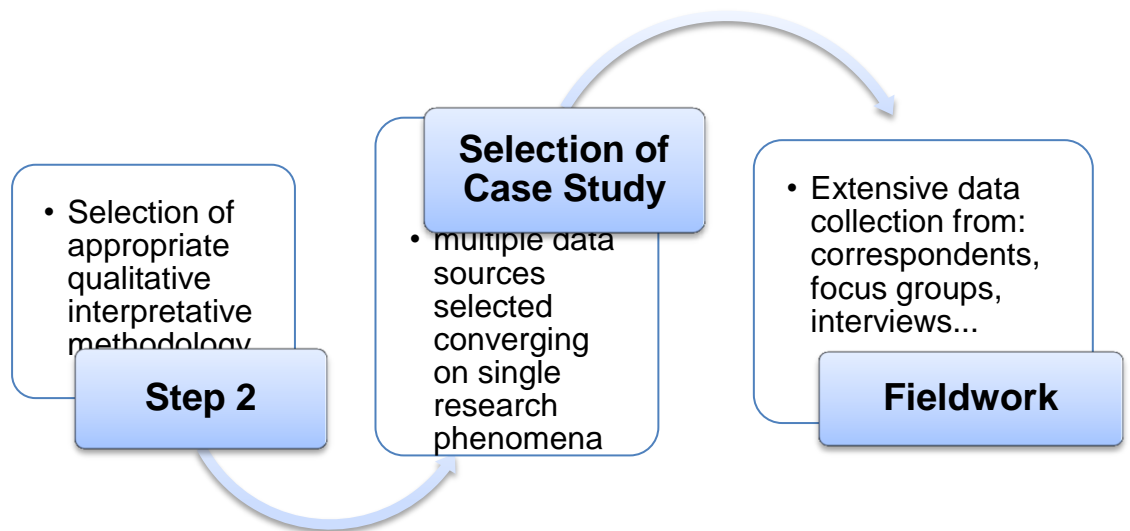


Figure 16 shows the second step in theory generation

Here, initial data illustrating participants' experience of prison healthcare was derived from their correspondence. Theoretical saturation was considered to have been reached when the 14 initial research themes were identified and no new categories could be elicited from the data. This satisfied Glaser and Strauss's test of empirical confidence showing that these initial categories had been saturated (Glaser and Strauss, 1967). Glaser and Strauss (1967,

p.65) further assert that there are no limits to the techniques deployed to collect data for theoretical sampling. The multiple units of analysis demanded by the Case Study methodology, were, in consequence, used in this study. The method of data collection for Phases One to Five was described in full in Chapter Three.

The extensive quantity of research data collected throughout this study was inputted and simultaneously analysed within the data analysis software packages previously outlined. This data was coded and ordered alphabetically for ease of reading.

Figure 17

Data Analysis and Theory

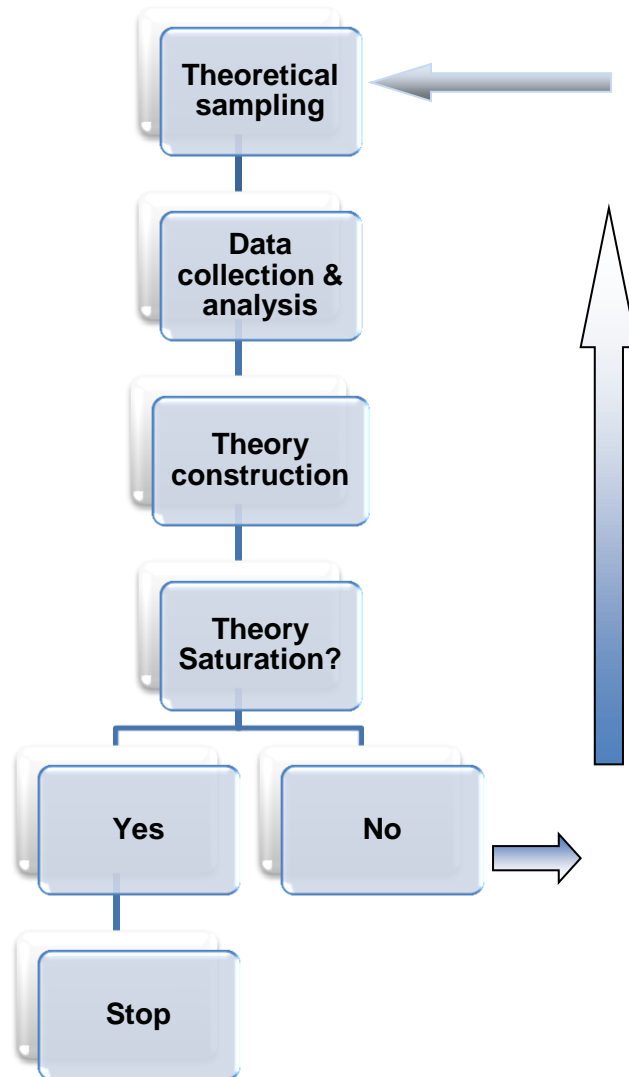
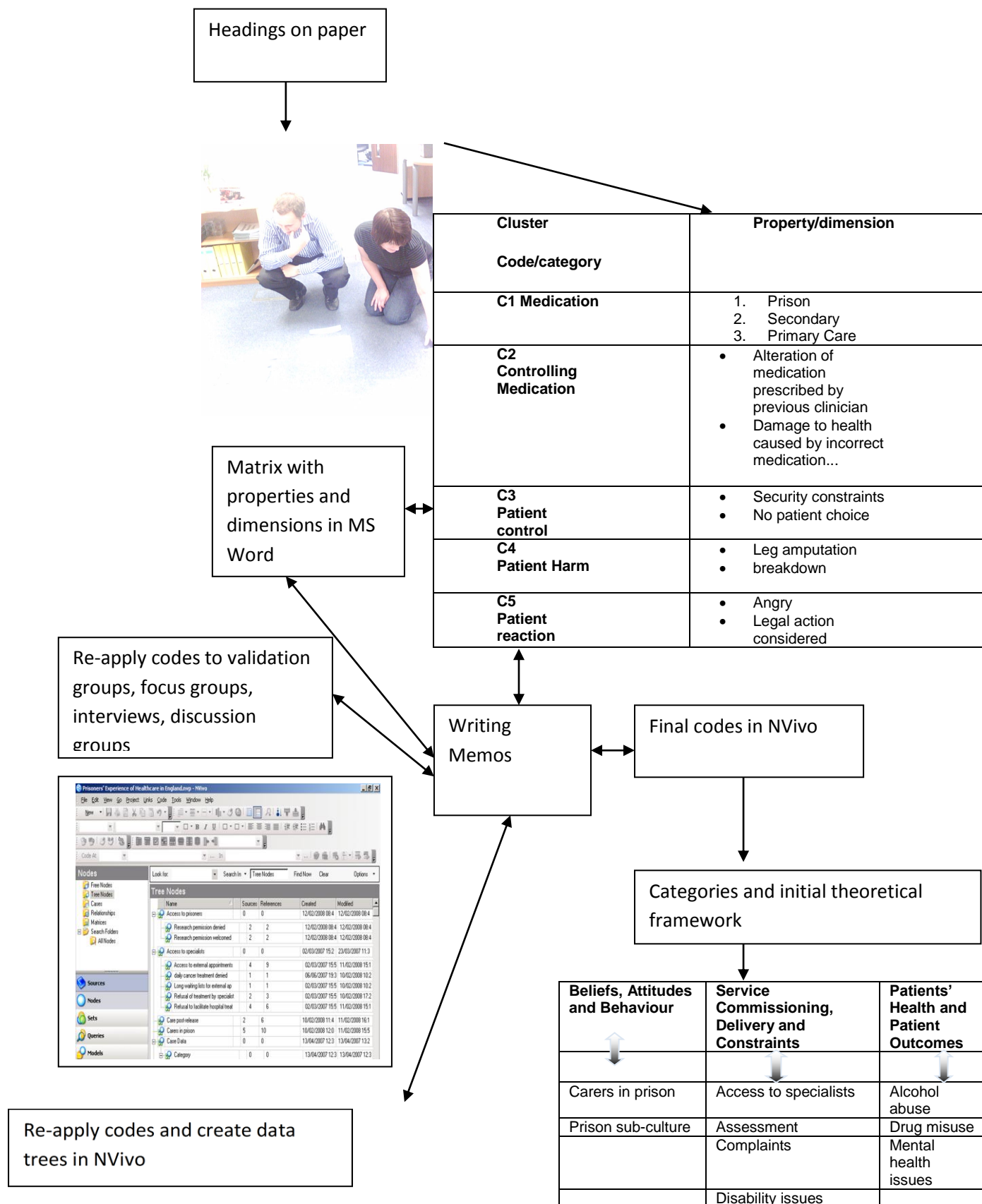


Figure 17 showing the Inter related process of data analysis and theory generation

The process outlined required meticulous coding of the data. Six methods are considered “part of grounded theory’s coding canon: *In Vivo*, Process, Initial, Focused, Axial and Theoretical” (Saldaña, 2009).

Initial Coding, previously referred to as Open Coding was initially applied to this study’s data to break it down into individually coded segments. This was achieved via a combination of both manual coding supported by Colazzi’s method and computerised coding as previously described. As the preferred learning style of the researcher, the process of diagramming (Glaser, 1978) proved a valuable method of visual representation of the extensive data collected thus far. This process is represented in Figure 18 to follow.

Figure 18
Coding Process



Thus the 24 research themes were identified. The second cycle of coding was required both to:

[...] literally and metaphorically constantly compare, reorganise, or 'focus' the codes into categories, prioritise them to develop 'axis' categories around which others revolve, and synthesize them to formulate a central or core category (Saldaña, 2009, p. 42).

Figure 19
Grounded Theory Step 3

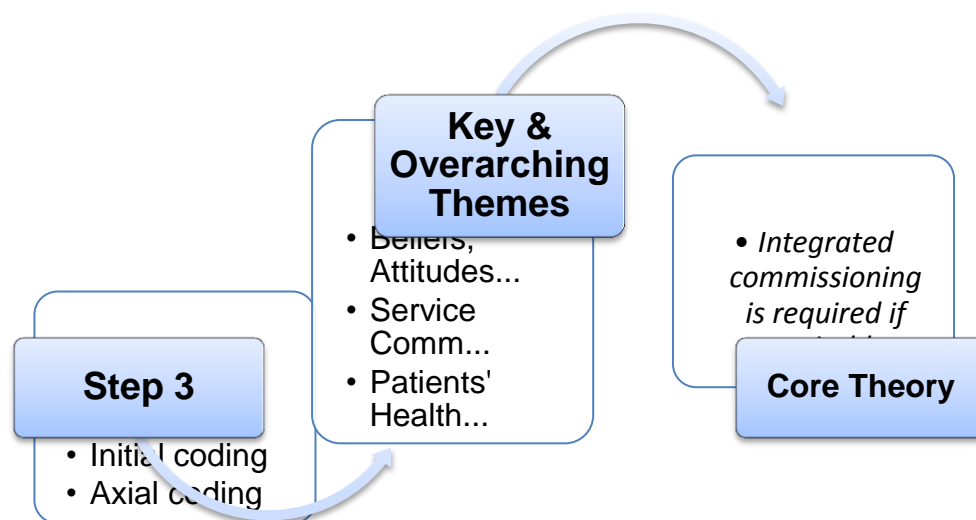





Figure 19 shows the third step in theory generation

Through this process, it was discovered that this study's data clustered into three Key categories. These are presented in Table 15 to follow:

Table 15
Key Themes

Beliefs, Attitudes and Behaviour	Service Commissioning, Delivery and Constraints	Patients' Health and Patient Outcomes
		
Carers in prison	Access to specialists	Alcohol abuse
Prison sub-culture	Assessment	Drug misuse
	Complaints	Mental health issues
	Disability issues	
	Dispensary opening times	
	External support	
	Healthcare facilities	
	Healthcare staff	
	Medical records	
	Medication	
	Prison environment	
	Prison hygiene	
	Prison regulations	
	Prison staff	
	Privacy	
	Social care	
	Treatment	
	Variation in healthcare	
	Waiting times	

4.12 Developing Themes into a Core Theory

The three Key Themes were then linked to the central core category, *Patient Equivalence*. Rejecting Glaser and Strauss's (1967) concept of *hypothesis* at this point in favour of Yin's (1994) *driven to theory concept*, the overarching theme identified will be used in Chapter Five to highlight imprisoned patients'

experience of equivalence beneath each of the research themes presented. It will also be used in Chapter Six to generate the Core Theory arising from this study.

This evolutionary process from themes into one core theory can be seen diagrammatically in figure 20 to follow:

4.13 Core Theory

Figure 20
Core Theory Model

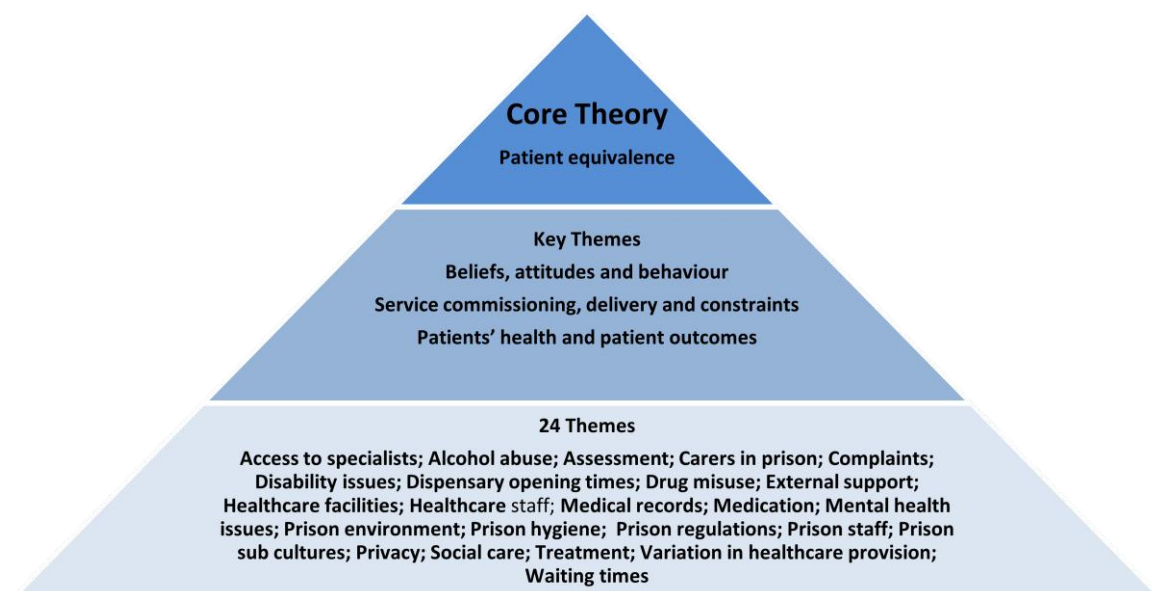


Figure 20 above showing Themes and Key Themes leading to Core Theory identified in this study

The following section (excluding sub-categories which are too numerous for the model above) presents its constituent parts in alphabetical order. The tables also provide a complete list of the sub-categories identified for each node. The Key Theme and Overarching Theme *Patient Equivalence* is also presented.

Table 16**Access to Specialists**

Sub-Category	Access to external appointments, daily cancer treatment denied, handcuffed in public, long waiting lists for external appointment, patient manipulation of system to access external specialist treatment, refusal of treatment by specialist, refusal to facilitate hospital treatment
• Theme	Access to Specialist
• Key Themes	Service Commissioning and Delivery
• Overarching Theme	Patient Equivalence

Table 17**Alcohol Abuse**

• Sub Category	Prisoners Hiding Addiction
• Theme	Alcohol Abuse
• Key Themes	Patients' Behaviour, Health and Outcomes
• Overarching Theme	Patient Equivalence

Table 18**Assessment**

• Sub Category	Inadequate Assessment
• Theme	Assessment
• Key Themes	Service Commissioning and Delivery
• Overarching Theme	Patient Equivalence

Table 19**Carers in Prison**

• Sub Category	Female carers, male carers, young carers
• Theme	Carers in Prison
• Key Themes	Patients' Behaviours, Health and Outcomes
• Overarching Theme	Patient Equivalence

Table 20**Complaints**

• Sub Category	Complaint information not provided, complaint may be intercepted, complaint not taken seriously, concern by complainants that staff were untruthful, fear of punishment for reporting issue, had to log complaint to person complained regarding, high level of complaints against same clinician, malicious staff reaction
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	to prisoner complainant, medical information not provided for complainant, non-NHS provision exempt from complaints process, reduction observed in number of complaints, solicitor unable to assist, unable to access photocopier to assist complaint
• Theme	Complaints
• Key Themes	Service Commissioning and Delivery
• Overarching Theme	Patient Equivalence

Table 21

Disability Issues

• Sub Category	Inaccessible Prison Estate
• Theme	Disability Issues
• Key Themes	Healthcare Setting
• Overarching Theme	Patient Equivalence

Table 22

Drug Misuse

• Sub Category	Addiction issues, delays in prescribing, detoxification cold turkey, detoxification programme (reverse affect on prisoner medication), drug threat to stay clean, holistic care, inappropriate prescribing, positive drug test and refusal to otherwise treat, refused drug
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	treatment programme, threat from other prisoners
• Theme	Drug Misuse
• Key Themes	Patients' Behaviour, Health and Outcomes
• Overarching Theme	Patient Equivalence

Table 23

External Support

• Sub Category	Concern for family member, inability to maintain family contact, li-reach unavailable, lack of appropriate adult, lack of key worker, poor solicitor damaging mental health, prisoner attitude towards external provision, social worker unavailable
• Theme	External Support
• Key Themes	Healthcare Setting
• Overarching Theme	Patient Equivalence

Table 24

Healthcare Facilities

• Sub Category	Dispensary opening times, good service provided, improved facilities, lack of privacy, mental health facilities required, no access to palliative care, no facilities for disabled, no self-help, no Well-Woman Clinic, no translation facilities, overcrowding, poor food, unhygienic
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	healthcare facilities
• Theme	Healthcare Facilities
• Key Themes	Healthcare setting, Service commissioning and delivery
• Overarching Theme	Patient Equivalence

Table 25

Healthcare Staff

• Sub Category	Caring attitude of healthcare staff, doctor's poor grasp of spoken English, flexible staff attitude, healthcare forming united front against patients, healthcare staff (improved quality), human rights contravened by healthcare staff, inexperienced agency staff use, insufficient staff, lack of healthcare knowledge and understanding of complex medical issues, nurses undermining doctors' decisions, patients' hostility towards healthcare staff, poor staff attitude and prejudice, racism, rapid doctor turnover, staff stopping medication, staff threats, uncaring attitude of prison medical staff
• Theme	Healthcare Staff
• Key Themes	Service Commissioning and Delivery
• Overarching Theme	Patient Equivalence

Table 26**Medical Records**

• Sub Category	Hospital not forwarding medical records, medical information not requested, no medical records system
• Theme	Medical Records
• Key Themes	Healthcare setting, Service Commissioning and Delivery
• Overarching Theme	Patient Equivalence

Table 27**Medication**

• Sub Category	Damage to health caused by incorrect medication, delay in receiving prescribed medication, incorrect medication, insufficient medication, medication being tampered with, medication denied, medication thrown away, patients bullied to give medication to other prisoners, patients selling medication, prescribed methadone unsuitably, previously prescribed medication denied, proactive treatment, refusal to allow painkilling medication, sufficient medication
• Theme	Medication
• Key Themes	Healthcare setting, Service Commissioning and Delivery
• Overarching Theme	Patient Equivalence

Table 28**Mental Health Issues**

• Sub Category	Mental Health Deteriorating in Prison
• Theme	Mental Health Issues
• Key Themes	Patients' Behaviour, Health and Outcomes
• Overarching Theme	Patient Equivalence

Table 29**Prison Environment**

• Sub Category	Exercise, prison food, prison overcrowding, The <i>Churn</i> (rapid movement of prisoners around the prison system), unhealthy environment
• Theme	Prison Environment
• Key Themes	Healthcare setting, Service commissioning and delivery
• Overarching Theme	Patient Equivalence

Table 30**Prison Hygiene**

• Sub Category	Health and Safety
• Theme	Prison Hygiene
• Key Themes	Service Commissioning and Delivery

<ul style="list-style-type: none"> Overarching Theme 	Patient Equivalence
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Table 31

Prison Regulations

<ul style="list-style-type: none"> Sub Category 	Governor overriding medical opinion, poor treatment led to increase in sentence, prison regime blocked access to care, prison regulations put before healthcare, seclusion
<ul style="list-style-type: none"> Theme 	Prison Regulations
<ul style="list-style-type: none"> Key Themes 	Healthcare Setting, Service Commissioning and Delivery
<ul style="list-style-type: none"> Overarching Theme 	Patient Equivalence

Table 32

Prison Staff

<ul style="list-style-type: none"> Sub Category 	Caring attitude of prison staff's, prison staffs' hostility towards healthcare staff, uncaring prison staff
<ul style="list-style-type: none"> Theme 	Prison staff
<ul style="list-style-type: none"> Key Themes 	Healthcare Setting, Service Commissioning and Delivery
<ul style="list-style-type: none"> Overarching Theme 	Patient Equivalence

Table 33**Prison Sub-cultures**

• Sub Category	Compensation culture, prison culture, prisoner culture
• Theme	Prison sub-cultures
• Key Themes	Patients' Behaviours, Health and Outcomes, Healthcare setting
• Overarching Theme	Patient Equivalence

Table 34**Privacy**

• Sub Category	Lack of facilities for private consultation, letters read by prison staff, prisoners hiding conditions from staff and others
• Theme	Privacy
• Key Themes	Service Commissioning and Delivery
• Overarching Theme	Patient Equivalence

Table 35**Social Care**

• Sub Category	Lack of social care, older prisoners, sick and vulnerable prisoners
• Theme	Social care

• Key Themes	Service commissioning and delivery
• Overarching Theme	Patient Equivalence

Table 36

Treatment

• Sub Category	Delay in specialist equipment, denied medical treatment, different treatment by healthcare staff dependent on prisoner status, discriminatory treatment, failure to access healthcare prior to imprisonment, fear health deteriorating, governor improved treatment, insufficient medical investigation, involved media to access treatment, lack of information about medical condition, lack of mental health treatment, needed to involve solicitor to access treatment, no rehabilitation for those with mental health issues, no specialist treatment, placed in wrong institution for patient's needs, poor service (treatment and care), results not given to patient, specialist treatment denied (mental health unit), specific treatment not available, treatment based on risk you pose to prison, treatment decisions not taken by doctors, treatment worse inside prison
• Theme	Treatment
• Key Themes	Healthcare Setting, Service Commissioning and Delivery
• Overarching Theme	Patient Equivalence

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Table 37

Variation in Healthcare Provision

• Sub Category	Wait worsened condition, wrong treatment, incorrect treatment prescribed against specialist hospital consultant report
• Theme	Variation in Healthcare Provision
• Key Themes	Healthcare Setting, Service Commissioning and Delivery
• Overarching Theme	Patient Equivalence

Table 38

Waiting Times

• Sub Category	Delay in external results, difficult accessing healthcare, waiting time chiropodist, waiting time dentist, waiting time doctor, waiting time optician, waiting time specialist
• Theme	Waiting times
• Key Themes	Service Commissioning and Delivery
• Overarching Theme	Patient Equivalence

4.14 Conclusion

The multiple and varied data sources presented in this chapter were faithful to Foucault's concept of the "polyhedron of intelligibility" (1981, p. 6), as demanded by an effective Case Study.

Analysis also considered the considerable fieldwork access difficulties and aspects of potential researcher bias. This did not prevent the gathering of the rich, relevant and in-depth data required by the adopted Case Study approach specific to this work.

The extensive volume of qualitative fieldwork data collected for this research requires a separate chapter to present and analyse fully, next.

CHAPTER FIVE: PRESENTATION AND ANALYSIS OF THE FIELDWORK FINDINGS

Why do people do research in prisons? Any research is usually driven by personal curiosity, but often the particular world selected (or landed upon) and particular topic chosen resonates with some conscious or unconscious value or interest whose origins pre-date the research project. So what particular features of the prison world draw the curious in? What are its key 'themes'? Prisons are potentially dangerous settings. For those few who venture in, the answers will differ among researchers...

Liebling (1999).

5.1 Introduction

This chapter presents and debates the experiential data arising from this study and it is structured to present the 24 themes identified from the coded data arising from the detailed work conducted in Chapters Three and Four of this thesis.

Table 39

Complete List of Themes

The contents of this table are presented in alphabetical order.

Number	Theme
1	Access to specialists
2	Alcohol abuse
3	Assessment
4	Carers in prison
5	Complaints
6	Disability issues
7	Dispensary opening times
8	Drug misuse
9	External support
10	Healthcare facilities
11	Healthcare staff
12	Medical records
13	Medication

14	Mental health issues
15	Prison environment
16	Prison hygiene
17	Prison regulations
18	Prison staff
19	Prison sub-cultures
20	Privacy
21	Social care
22	Treatment
23	Variation in healthcare provision
24	Waiting times

A brief description of each theme is presented from section 5.1.1 to follow, and the tables of findings appear in alphabetical order. These will present each theme in turn, as well as the sub-categories relatable to each. In drawing together this data, three broad themes (referred to below as Key Themes) emerged from the analysis as presented below:

1. Healthcare Setting,
2. Patients' Behaviours, Health and Outcomes,
3. Service Commissioning and Delivery.

Finally, an overarching theme, *Patient Equivalence* was also identified. This, along with the three Key Themes presented above, is discussed fully in this chapter and Chapter Six. Participant **correspondent data** (own written text as received), in this section, is presented in Times New Roman typeface to permit differentiation from focus group, discussion group and interview data, and analytic debates. **Participant correspondents' grammar, syntax, punctuation and spelling are presented as received.** The rationale for this is aimed to, firstly, maintain the authenticity of each account and, secondly, to illustrate the diverse levels of literacy for this population.

5.1.1 Access to Specialists

The focus here is imprisoned patients' abilities to access specialist care. Seven sub-themes are identified for this theme. These demonstrate participants' perceptions of the negative impact this has on their psychological and emotional well-being. In the case of external appointments, these are defined as any health-related treatment a patient may require in a healthcare

facility outside prison. This definition includes mental health treatment facilities. It also includes treatment in hospital and specialist NHS trusts.

- Access to external appointments

Psychological damage caused by patients' inability to access the doctor of their choice is an interpretation offered by this study, and is highlighted in this female correspondent's quotation: "For three years in prison I wasn't allowed outside to see my own doctor.

Here, this participant disclosed a complex long-term medical condition. She felt this would be improved through access to her own primary care physician, who knew her illness and her treatment. Further, she described a situation where not only did she feel that she was denied an opportunity for a consultation/treatment review with her own doctor but, she also believed that the prison refused to liaise with him on her behalf. Her frustration regarding this lack of choice, she said, had created an intolerable situation. As a result, she believed both her physical and psychological health had been significantly harmed.

This contradicts English patients' "right to choose a GP" promised in the NHS Plan (Department of Health, 2000a, p.89). The situation illustrates a problematic aspect of delivering genuine patient choice (Department of Health, 2004) within a secure setting.

- Daily cancer treatment denied

The inability to access specialist opinion/treatment was not confined only to the prison primary care interface. For example:

I believe I am part of the reason why the health care got changed to the national health service as I am dieing [sic] of Prostate cancer, and yes I do believe I am not getting the right treatment because I am in prison. I have asked for radical radiotherapy but because this means going to hospital dayley [sic] all I am being given is Bicalutamide 150mg a day, so I do feel my treatment would be a lot better if I was not in here: male correspondent.

The inability of prison healthcare to adequately care for dying patients in an equitable manner was also reported in this study. In the case above, the male

correspondent believed that he could not access the care he needed because the prison did not have the necessary drugs and treatment facilities. He felt strongly that his incarceration had led to him receiving poorer treatment than others with similar conditions in the external community. Thus, this participant highlights issues regarding the inequitable nature of healthcare in relation to his own experience.

Despite the epidemiological nature of a large proportion of prison literature reported in Chapter Two, there are very few studies investigating cancer care for this patient group in England. In an American study, however, Lin and Mathew (2005, p. 467) hypothesised that primary care in prison faced “unique obstacles” to effective treatment and pain management for cancer patients.

The high level of smoking, STIs, substance abuse and ill health prevalent suggests that this population is likely to experience high cancer rates. The prevalence of cancer and other serious illness are also issues which disproportionately affect the older population. The increasing aging of the prison population is also likely to be a factor. This study, therefore, supports Davies *et al*'s. (2010) call for future work to investigate cancer incidence, screening, timeliness and access to cancer treatments and end-of life care as prisoners are likely to require both treatment and support.

- Handcuffed in public

The findings for this theme also draw attention to the issue of being handcuffed in public which was problematic for participants. The young person interviewee described his trip to hospital in handcuffs as:

[...] the most humiliating experience of my life. They took me out dressed in my prison uniform handcuffed to an officer either side of me with little kids looking at me with wide eyes and little old ladies and gents would be looking at you like what you in for.

This embarrassment of being handcuffed in public was also identified by correspondents, validation, and focus group members. One older participant in the validation group asserted that when someone was not in a physical position to run, they should not be handcuffed. This, the group concurred,

would allow them to access healthcare like the rest of the community. They would not, therefore, face the adverse reactions of other patients and hospital medical staff alongside stigma and its associated effects.

The embarrassment to participants was clearly evident during face-to-face discussions with those who had been in this position. Another participant in the same group said he felt it was “ironic” that, having been previously allowed out of the prison unaccompanied to attend a funeral, he was handcuffed to two prison officers shortly afterwards when he went for an Magnetic Resonance Imaging (MRI) scan. During this exchange, he turned to the rest of the group and shrugged his shoulders. Others clearly emphasised, nodded and laughed.

A female correspondent also spoke about being handcuffed in public despite her advanced age and physical frailty. She described a prison system which had failed to apply a sensitive assessment, informed by the risk patients posed to others, and believed that this should be changed.

This experience contradicts one of the main recommendations in the *Dignity in Care Public Survey* (Department of Health, 2006, p. 4) which states: “It is important for service users to maintain a respectable appearance when they are receiving care”. Despite this survey being conducted a year post-transfer of prison healthcare to NHS responsibility, prisoners, prison staff and departments were excluded from this consultation. This suggests that, at the time, this important community was still not fully embedded in the Department’s strategy.

At a local level, the decision whether or not to handcuff a patient is one taken by the prison/police, as the female participant above was clearly aware. This issue, therefore, falls outside NHS staff jurisdiction and services which are instructed to follow policy in the locality. Their focus is solely on the treatment of the patient. Here, the interface between the criminal justice system and NHS policy and practice do not correspond.

As exemplified by this study’s data, this lack of joined-up approach and commissioning regarding prisoner healthcare is problematic. Further, this

suggests a lack of sensitivity to imprisoned patients' needs, where security concerns prevail regardless of healthcare requirements or suitability of these measures.

- Long waiting lists for external appointment

The difficulty which patients faced when trying to access external appointments was another issue narrated. This was particularly the case for routine tests and investigations such as X-rays. The male correspondent's quotation below illustrates the extreme waiting time for this investigation: "The hospital told me I would only wait 28 days for an X-ray – not the case!"

Another male focus group participant pulled up the leg of his trousers during the group discussion to demonstrate that his broken ankle had healed badly. The joint was visibly disfigured with a large swelling approximately the size of a small orange. As result, he claimed, his mobility was now impaired. This injury was almost a year old, and he believed that this had arisen because he had not been taken to hospital for an X-ray. When, later, this individual walked out of the focus group with the researcher at the end of the session, he had a profound limp and winced with pain.

This study was unable to identify any nationally held patient information relating to injury, and service access levels for English prisoners. In its absence, it is difficult to identify whether there is an inequity in service delivery, as this participant claimed. Hence this gap in patient data requires attention.

- Patient manipulation of system to access external specialist treatment

This issue relates to the length of time participants experienced awaiting specialist treatment. This was reported to have run into several years in the case of three male correspondents. One male focus group participant stated that he had developed an ability to play the system to his own advantage. He said that his own strategy of "waiting until Sunday afternoon to collapse" (when healthcare was closed) was common for people in need of specialist treatment. He, and others, would then be assured someone would call for an ambulance to take them to the hospital. This issue appeared to be widely

known and accepted amongst other group members, a number of whom nodded in agreement. One male focus group member commented, “Sometimes you just have to wait till the staff aren’t around”.

In contrast to the apparent widespread awareness within the group, this study did not identify that prison staff were aware of this practice.

- Refusal of treatment by specialist

The testimonial below from a transgender correspondent illustrates some of the complex difficulties imprisoned patients consider they face when trying to access specialist external treatment. It highlights the issue of broad discrimination caused by the intransigent power of the penal system. This inability/unwillingness to transfer people to more suitable prisons within which appropriate healthcare can be facilitated was another omnipresent feature in this study. Within this broad population, minority groups with particular need were also identified, supporting previous findings in the literature (Bradley, 2009; Home Office, 2007; Edge, 2006). In the case of transgender people, such as the female correspondent featured below, little is currently known: “I was told I could not receive treatment for my gender identity disorder because I am in a Category C prison”

The majority of transgender research is conducted internationally and the Australian work of Edney (2004) is particularly relevant. The author highlighted the extreme vulnerability to sexual attack in prison, poor or inappropriate medical care and a failure to uphold transsexuals’ rights. In England, it is not known how many transgender prisoners are housed inappropriately in prisons holding the opposite sex. The three transgender correspondents in this study were all male-to-female. In each case, they were housed in male establishments. Given the cramped overcrowded conditions and paucity of washroom and other facilities, it is not hard to conjecture an intolerable existence for this group.

In England, rights were afforded to this community under the *Gender Recognition Act 2004*. This Act came into force in April, 2005 giving transgender people the right to be recognised as their identified sex for all

purposes. Here, the participant wrote to the study after this Act had been implemented. Because this individual was a correspondent, it is not possible to know whether she had applied for a Gender Recognition Certificate under the terms of the Act, and, if she had done so, whether she would have been moved from a male establishment. The scarce research in this area in England is lamentable.

- Refusal to facilitate hospital treatment

The expense of moving and escorting prisoners to external appointments was raised by participants, as demonstrated in the quotation below:

All I could move was my eyes. Only thorough threats from solicitors did I get to an outside hospital where the specialist did not know what the problem was and moving a Cat A prisoner in and out of hospital was too expensive: male correspondent.

On a related matter, a prison officer recounted the recent movement of a patient who had required heart surgery. This, she said, had required a police escort for the prison van, police cars placed strategically on motorway bridges along route, and a police helicopter flying overhead. The cost, she said, had been “astronomical” and had been something the prison could ill-afford.

She was also frustrated with the fact that many “high risk” prisoners refuse their hospital care when such arrangements are in place. They do so, she felt, because they have been given no opportunity to inform their family about their imminent (and, in some cases, potentially life-threatening) surgery. In her view, this arose because the prison is not permitted to inform the patient in advance (in such cases), as this would result in a heightened risk of escape. On further reflection, this prison officer posited that the situation was also expensive for the hospital concerned, for it was routine to clear half a day’s operating list to accommodate security requirements in such cases.

This issue results from the incompatibility between the need for outside specialist healthcare and the demands of a secure regime. For imprisoned patients, this situation, and others like it, were clearly inequitable. The need to protect the public from harm, however, overrides all such considerations, and it is difficult to find an obvious solution.

5.1.2 Alcohol Abuse

Drinking to a level considered dangerous to health is the definition used here (Department of Health, 2008g). One sub-theme identified illustrates prisoners' abilities to access alcohol in prison. It further highlights this population's ability to continue drinking to excess in prison, despite the prison mechanisms in place to prevent them from doing so.

- Prisoners hiding addiction

Participants displayed a real understanding regarding the ability of some to obtain alcohol. The comment below is the reflection of one focus group participant. She noted the way that some women in her prison drank frequently to excess whilst on day-release. They had, she said, managed to time the moment they stopped drinking "to the minute" to ensure they passed the prison's alcohol screening tests on their return to secure conditions. She was particularly concerned that this practice would be discovered and feared the potential repercussions for everyone else. This issue clearly left her angry and frustrated:

They can't just give free licence to everyone to do as they like. Once someone takes advantage it starts reflecting on everyone. They need to be risk assessed in the appropriate manner: female focus group participant.

Thus, female focus group participants demonstrated a sophisticated understanding regarding prisoners' ability to manipulate prison rules in order to hide their continued drinking. This covert practice appears to cast doubt on Plugge *et al*'s. (2006) isolated finding that alcohol consumption for women fell during their time inside. It would instead support the wider body of literature which suggests that, in contrast, drinking to excess remains problematic (Easteal, 2001; Joint Prison Service and National Health Service Executive Working Group, 1999; Keil and Samele, 2009; Ramsbotham, 1996).

Dangerous levels of alcohol consumption, another female focus group participant acknowledged, was as widespread in open and semi-open prisons. She believed that alcohol abuse amongst women was a serious problem in the prison system. Young women in particular, she added, were "driven to drink",

in order to forget prior sexual abuse. This supports the anxiety reduction explanation offered previously in the literature (Hussein Rassool, 2006; Hussein Rassool, 2009). In this participant's opinion, the prison authorities were unaware of the true level of alcohol addiction in prison. "These women, particularly the young ones, get off their face then come back here like nothing's happened. Sweet" *[uttered sarcastically]*.

5.1.3 Assessment

Prisoners are subject to many forms of assessment during their time in prison. On entry, it is recommended that prisoners undergo an assessment of their health status which can highlight any treatment and medication needs. However, this practice was found to vary widely. Appropriate assessment, as an enabler of individual treatment plans, is an essential facilitator of effective healthcare and treatment.

- Inadequate assessment

Poor assessment was highlighted to be an issue along the entire criminal justice pathway. One female focus group member, for example, recounted her lack of assessment at the early stage of her entry into the judicial system. This, she said, meant that prisons were largely unaware of the health needs of their future patients, leaving them ill-equipped to cope with some of their acute and complex care needs.

Other group participants endorsed this view, and said they were powerless to do anything about it. Correct assessment, she added forcibly, could also contribute towards preventing admission into inappropriate establishments which were "not equipped, or able to care for prisoners requiring specialist expertise". This issue was also raised by participants of the male focus group, and one man, speaking about his own initial health assessment said "another prisoner did it, height, weight, that's it!"

This participant was clearly amused by the episode, which he considered was indicative of the experience of many. As a life-sentenced inmate, he had been resident in a number of establishments over the years. He complained

bitterly that, in his experience, healthcare assessment was inadequate throughout the prison system. This left prisoners both vulnerable and poorly treated/medicated.

The vulnerability of the sick in prison has been widely acknowledged by Loucks (2004) and Yorston (2004) amongst others. Demonstrating another key strength of the focus group approach, the researcher was able to observe the participant above directly. In this case, the man in question was approximately 6 feet 2 inches tall, and large and heavily built in stature. His forearms were covered in prison tattoos, and he carried an air of superiority amongst other group members. It is obvious that the physically strong, as well as the weak previously highlighted, are rendered disempowered/vulnerable by the poor practice highlighted.

Moreover, the issue of variability of healthcare assessment depending on the nature of the prison sentence is acknowledged here. In 2009, Brooker *et al.* found that short-sentenced prisoners had significantly worse health than the general population. The authors asserted that “clear areas where healthcare is not currently sufficient” were found (Brooker *et al.*, 2009, p. 31). These finding should, however, be treated cautiously, as only 35% of the target participant sample (n=73) took part in the research.

5.1.4 Carers

The experienced absence of formal carer provision across the prison system is one of the most pertinent findings of this work. Crucially, it is the adoption of these roles by other prisoners that is most interesting.

- Carers in prison

Carers are people who take on the care of another long-term sick or disabled person, who relies on their *regular and substantial care*. This characterization would fall within the definition of the *Carers (Recognition and Services Act)*, 1995 (Great Britain, 1995), *Carers and Disabled Children Act 2000* (Great Britain, 2000), *Carers (Equal Opportunities Act 2004* (Great Britain, 2004) and the National Strategy on Carers *Carers at the heart of 21st Century ‘A caring*

system on your side. A life of your own' (HM Government, 2008). The imprisoned carers identified here are adult male, adult female and young people. The needs of those cared for are wide ranging, to include: heart disease, Alzheimer's disease, mental health issues and physical frailty caused by aging.

- Female carers

Participants caring for sick and vulnerable prisoners were also identified within this study. Although both men and women said they had adopted this role, there was a perception, amongst women, that this was not the case. One female focus group participant, when observing the study's graphic board displayed on the table, said that women were more caring than men in prisons because "it is what women do". The thought that men cared for one another amused the group who laughed out loud at the idea. This misunderstanding of practice in male estate, about which women participants were clearly curious, was an underlying and persistent feature of this study.

Another female in the group said that women felt their best source of support was other imprisoned women, and commented that "women stick together". She said that sometimes there is no alternative to caring for another woman, as the facilities required can be "totally absent in many prisons".

- Male carers

It was a male validation group participant who first spoke about the care he provided for an elderly male prisoner. The cared for prisoner resided on his landing and had Alzheimer's disease. This care included assisting the elder with going to the toilet, showering, feeding, and helping him to take his medication. As he spoke, the elderly man in question stood up and walked unsteadily towards him. Clearly confused and frail, he smiled when his carer touched his arm, thus showing his rotten teeth, a number of which hung loosely at the front of his mouth.

This carer also mentioned that prisoners are not allowed to care in prisons in a formal sense, and that his activities, if discovered, would lead to him getting

“nicked”. He complained bitterly that he was left to struggle alone, and without any information and support that could be useful to him. The prison was, however, he noted dryly, quick to “turn a blind eye” if the cared for soiled himself and required showering to “reduce the stench on the landing”.

It is important to note here that participants mentioned numerous incidences of informal caring. This aspect of care provision has, therefore, remained absent from the health and social care literature that relates to the criminal justice system and incarcerated offenders.

The lack of support or recognition for the role informal carers play within prisons was, said another male focus group participant, leaving vulnerable patients at risk of abuse. This, he considered, would be the case where frail or cognitive impaired prisoners required assistance with social care tasks, such as showering and toileting. Training would be of great benefit to informal carers in prisons. The situation, he felt “should be openly acknowledged and the necessary support and backup be provided to those providing the care to others in prison”.

Although the women participants featured above doubted that men were carers in prisons, this study found material to the contrary. Male validation group participants, and the aforementioned male interviewee, as examples, spoke openly about their caring relationships. In one participating prison, prisoners had been offered a formal role as a care attendant for others. This was in a private male prison.

The emergence of informal carers who took on the caring role, unlike formal carers who provide health or social care as part of a contract, understanding or payment, did so as a result of a sense of obligation or regard for the cared for person. They also said they did so because they believed nobody else would. Therefore, reasons for this informal caring in prisons is here analysed as three-fold, occurring due to:

1. a lack of care alternatives,
2. empathetic concern and respect for the needy,
3. partly out of a sense of obligation for someone about whom they cared.

Examples emerged in the validation group that no risk assessment, or monitoring of these informal care arrangements, was apparent. Drawing attention to these issues, the researcher published an article in the *Health Service Journal*, in September 2008. This led to specific action on the part of the Department of Health to highlight the issue nationally and include imprisoned-carers in future strategic plans and risk assessments.

This commitment was important as this study found some indication of at least one prison turning a blind eye, or informally accommodating arrangements as featured earlier “H and me have a system. If he needs me he bangs on the wall”: male carer interviewee.

The interviewee above said that this arrangement had been in place for over a year. Prison staff had housed H and himself in adjacent rooms to facilitate his care giving.

- Young carers

The young participant interviewee said that, in young offender institutes, caring relationships formed because the young men already knew each other on the outside. This could suggest that an underlying previous friendship or kinship affected whether or not young people took on the role of informal carer in prison. He commented: “Um I suppose I mean you’ve got a lot of people in there are friends. They know each other from outside as well”.

Young females were not interviewed due to difficulties in accessing young offender institutes.

There is no previous academic research on this subject of informal care giving in prisons and establishments’ reactions to, and facilitating of, this practice.

5.1.5 Complaints

When prison healthcare transferred to PCT commissioning responsibility in 2006, imprisoned patients became entitled to bring forward health complaints,

under the *National Health Service (Complaints) Regulations 2004* (National Health Service, 2004). This was later amended by the *National Health Service (Complaints) Amendment Regulations 2009* (National Health Service, 2009). The Regulations also gave imprisoned patients the right to access the independent advocacy support, provided by Independent Complaints Advocacy Service (ICAS), stating that:

“Arrangements for the handling and consideration of complaints

3 (1) Each responsible body must make arrangements (“arrangements for dealing with complaints”) in accordance with these Regulations for the handling and consideration of complaints.

(2) The arrangements for dealing with complaints must be such as to ensure that-

a) complaints are dealt with efficiently;

b) complaints are properly investigated;

complaints are treated with respect and courtesy;

complaints receive, so far as is reasonably practical –

i) assistance to enable them to understand the procedure in relation to complaints; or

ii) advice on where they may obtain such assistance

e) complainants receive a timely and appropriate response;

f) complainants are told the outcome of the investigation of their complaint; and

g) action is taken if necessary in the light of the outcome of a complaint”.

Despite this clear entitlement which applied to all prisoners in receipt of NHS healthcare and treatment, data relating to the number of prisoner healthcare complaints is not published by the Department of Health. This makes it difficult to establish whether prisoners are under-represented amongst NHS complainants. The data below do, however, suggest that the issues reported make this likely to be the case.

This theme contained a complex range of 13 sub-themes for participants, suggesting the intransigent power of the penal system to repress healthcare complaints:

- Complaint information not provided

One male correspondent said “I have serious healthcare concerns I would like to take action as we can’t get any information regarding this subject here at all”. In this case, the participant said his healthcare complaint had “completely stalled”, because he had been unable to obtain from the prison any information to support his concern. This suggests a breach of points (d) i) and ii) above, and this individual should have been supported to access the ICAS service previously highlighted. The inappropriate response prevented this patient, either intentionally, or unintentionally, from pursuing his healthcare complaint. It further demonstrates patients’ experience of inequitable provision and their powerlessness in the face of poor practice.

On a related point, two male correspondents said that it was not until they threatened to get their solicitor involved that they were able to access complaints-related information. This perhaps suggests that prison complaints department/staff members were fearful of cost or other repercussions in such cases.

- Complaint may be intercepted

Imprisoned patients’ feared they would suffer reprisals if they complained in writing. This is aptly unveiled by the testimony of this male correspondent “I have two serious issues that is [*sic*] too serious to write on paper and post for fear of interception”.

This issue was also predominantly mentioned by women in the focus group and participants in the male validation group. One female correspondent said that a number of her complaint letters had been intercepted and destroyed by the prison. Another said that she was unable to be entirely frank about the severity of her concern, as she was fearful members of the prison staff would read the letter and become aware of this. Without exception, participants reporting this issue expressed trepidation that prison staff would react badly if they complained. Due to the sensitive nature of this study, only selected details of participants’ contributions have been used to protect individuals from being identified. Despite this, these comments engender real concern that

some participants' feared reprisal because they had either written to this study or taken part in a group discussion.

- Complaint not taken seriously

There was the perception amongst participants that prison staff did not take their complaint seriously enough. This quotation from a male correspondent is a good illustration of this "When I complained about healthcare at X prison, I was fobbed off and given the run around, so just gave up".

In this case, he also stressed that his complaint was not pursued because the prison refused to acknowledge it. He said that, in the end, he simply gave up. This is a clear breach of point (e) of the Regulations.

- Concern by complainants that staff were untruthful

A perception that prison healthcare staff are dishonest was raised by a male participant in the quotation below. Antipathy towards prison healthcare staff was also expressed by a member of the male validation group. Referring to prison healthcare as *them* was a commonly used term:

I'm having/had problems with the so called Healthcare (lack of), and subsequent lies due to 'THEM' [original emphasis] all displaying a united front AGAINST what is said was said and MANY inmates lack of just treatment, what is the point the system always wins!: male correspondent.

This testimonial demonstrates not only a belief that the prison system could effectively unite to prevent patient treatment, but also colluded to hide this fact. These less tangible barriers to effective patient complaints are, it could be argued, of even greater concern than the tangible barriers described previously on this issue. Here, the emphasis placed by this correspondent suggests real anger and frustration at this perceived injustice. His belief that imprisoned patients were powerless against the system ends on a note of hopelessness. The psychological damage inflicted on prisoners by the prison system has previously been well established (Clemmer, 1958; de Viggiani, 2007; Sykes, 1958). Ramsbotham (1996) also raised a related point that prisoners would return to society carrying their experience of their treatment inside with them.

A belief that prison healthcare staff hid issues or destroyed prisoner letters was a related point raised independently by two female correspondents, suggesting widespread inappropriate practice in this area. No previous material could be found regarding this issue, suggesting another area requiring urgent review.

- Fear of punishment for reporting issue

Participants also expressed their concern that complaining about healthcare provision would be viewed by staff as challenging the system. Two female correspondents spoke about their fear of retribution. This included concern regarding complaining about healthcare, fearing that even if they did, their complaint would be blocked. One female correspondent said that she would be “made to suffer” by the staff members involved.

- Had to log complaint to person complaint was about

A recurrent theme in participant letters highlighted their perceived inability to complain about poor care and treatment. Five male correspondents complained regarding a lack of privacy when making their complaint, and said that they often had to complain to the very person the complaint was about. The five correspondents included here came from different prisons, again suggesting that this is common practice. It does not, however, appear to breach the Complaints Regulations discussed previously which state that arrangements should be made which are reasonably practical. It does though highlight the lack of patient choice in the penal environment in contrast to what a patient in the external environment could reasonably expect in the same circumstances.

- High level of complaints against same clinician

Patient perception of poor GP performance was raised. A male correspondent said “one particular GP had at least 30 separate complaints against him”.

Male validation group participants highlighted that patients knew GPs by their reputation, and would go to great length to avoid those considered poorest performers. A member of the prison healthcare staff complained also that, in

his view, prison GPs have tended to be those individuals who found it difficult to find work elsewhere, or were nearing the end of their career. She felt it was essential that, if healthcare in prisons was to improve, the service needed to attract clinicians of high calibre, with a genuine desire to work in the service.

This matter supports the literature which shows that prison healthcare staff development had fallen significantly behind that in the wider NHS (Health Advisory Committee for the Prison Service, 1997; Plant *et al.*, 2002; Prison Reform Trust, 1985, 2008a; Reed and Lyne, 1997; Sim, 1990). It further demonstrates that the promise of *Patient Choice* (Department of Health, 2004) is not realised in the prison environment where the reality for patients is a single GP or other clinician.

It is important to also recognise that this participant's comments were made post-Shipman and Ayling, Neale, and Kerr/Haslam. In response to these appalling failures in GP practice, HM Government published in its report *The Government's response to the recommendations of the Shipman Inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries* that there had been a failure to:

[...] take sufficient account of complaints and concerns, a failure to join up information from different organisations, the failure to investigate serious allegations with an appropriate degree of rigour (HM Government, 2007, pp. 5-6).

The poor practice here suggests that imprisoned patients remain vulnerable and that lessons from the past are yet to be learnt.

- Malicious staff reaction to prisoner complainant

One male correspondent was of the opinion that his complaint would not be taken seriously by the PCT, because it had been brought forward by a prisoner. This is suggestive of imprisoned patients' perception that the wider healthcare system holds a prejudice against them. His quotation further highlights the problems patients face when challenging the authority of the prison, "If we make a fuss we're seen as anti-authority. This place needs kicking into touch": (male correspondent).

Being seen to object to the prison regime was also something participants did not take lightly. This was endorsed strongly by a participant in the male focus group who said “you have no idea how much trouble I’m going to be in Miss just for talking to you about this”. This comment concerned the researcher who had been intent to ensure that participants’ contributions could not be attributed to individuals in order to protect their identity. It was suggestive of participants’ belief that, regardless of these steps, they would suffer some form of prison staff retribution for having participated in this study. This was despite the Governor’s own endorsement of the study. This is an under-researched area in the literature. De Hart *et al.* (2009) found examples of some members of prison staff viewing prisoners as manipulative. However, victimisation, has been identified, is reported to take place between prisoners themselves (Lahm, 2008). Prisoner acts of concealment, such as the use of *Argot* (Hensley *et al.*, 2003; Kurtz, 1981), could suggest that some prisoners are fearful of prison staff awareness of their conversations/behaviours. This does require further investigation.

Speaking as early as 1967, Glaser (p. 12) commented that prison as an institution “is highly organised” to make prisoners “compliant”. The primary purpose for this, Glaser argued was the fundamental imbalance of the prisoner to staff ratio in favour of the former. Moreover, the current level of prison overcrowding in England will have done nothing to improve this, and both prison culture and regime are an ever-present force in this study.

- Medical information not provided for complainant

A major difficulty patients highlighted was the lack of access to the information they required in order to bring forward a complaint. Again this is in breach of the Regulations, highlighted by this male correspondent “He is making a complaint about his face being cut in prison but the hospital won’t supply the information”.

In this instance, the participant could not access his hospital records. This study found that the lack of effective transfer of patient information was widespread which is also in contravention of commitments made in the NHS Plan (Department of Health, 2000a). It was difficult to establish the cause of

these difficulties in all cases as illustrated in the quotation above. Common factors, however, such as the lack of electronic patient records and the *Churn* (colloquial term for the rapid movement of prisoners around the prison system) were recurrent themes.

- Non-NHS provision exempt from the complaints process

As the following male correspondent quote illustrates, patients in receipt of non-NHS provision are exempt from the NHS complaints process “I contacted the PCT and unfortunately at present the healthcare is still being arranged by the prison and not the NHS”. Participants describe a two-tier system in English prisons, in which private healthcare recipients have limited opportunities for redress. These patients are not entitled to support from ICAS and, therefore, lack access to independent advocacy to assist them in complaining effectively. This may be important for people whose literacy skills are of a lower level than the general population, as is often the case for prisoner participants (Prison Reform Trust, 2003; Social Exclusion Unit, 2002).

- Unable to access photocopier to assist complaint

As you may well appreciate we inmates cannot photocopy and file all correspondence, mores the pity, so the content, not being concise, as I took their ad at face value, is ill remembered word for word. I did send a copy to InsideTime so I MAY [original emphasis] be able to get that (or a copy) back if retained: male correspondent.

Another difficulty for healthcare complainants is the lack of access to administrative support and equipment in order to pursue their case, or maintain accurate records. The participant above also stated that his only option at each stage of his complaint was to copy long-hand his notes/records whenever he wrote to anyone regarding his issues. Generally, he said, the notes were not returned to him, which meant he laboriously had to repeat the process for each new recipient. Other pieces of basic equipment identified as potentially valuable to NHS complainants included word processors. However, access to these is not allowed due to the associated security risk.

- Reduction observed in number of complaints

In an isolated example of good practice, one participating male prison reported a reduction in the level of healthcare complaints “Better staff in our prison now, the last complaint had been about a toothbrush”.

In this case, the prison had established a Healthcare Forum, owned and led by the prisoners themselves. The focus group participant above was a member of this. He explained that patients were actively encouraged to raise any healthcare issues.

On their behalf, one participant said, focus group participants actively pursued issues promptly with the relevant person/department. Over the months, one participant reported that healthcare had made significant improvements in its provision. The prison had even opened a Saturday morning health clinic, after patients had complained that they were unable to access the weekday clinic (which closed before their return from work duty). Patients, he said, were as a result much happier with provision and “felt listened to”. He added that the receipt of only minor healthcare complaints recently told him that “things had improved dramatically” with the prison’s healthcare provision.

Following the male focus group discussion, the Healthcare Governor reported that the Saturday morning clinic, which had been spoken of so highly by this participant, would shortly have to close because it was proving too expensive for the prison healthcare budget. He had yet to “find the courage to tell the group”.

- Solicitor unable to assist

This study found support for the extensive use of solicitors’ services (prisoners are entitled to the free services of solicitors throughout their time in prison). Three male correspondent participants reported having attempted to access legal support, only to be told their issues fell outside the solicitors’ remit. Writing to solicitors for assistance with healthcare complaints, one healthcare lead said that the receipt of a solicitor’s letter tended to confuse matters. When they received these, she said, complaints staff were unsure whether

patients wished to pursue the NHS complaints procedure, or sue the prison. Solicitors' roles in relation to healthcare complaints are confusing, leading to frustration for some:

It was very poignant to me when in [sic] read your piece, as I wrote a letter to a firm of solicitors 'X' who advertise, 'can I help you with prison matters', ONLY [original emphasis] to have a letter BACK saying sorry CANNOT help with Healthcare matters!?!%@#!: male correspondent.

The above testimony is a further illustration of the way in which prisoners find creative means to make their feelings heard when presented with the opportunity to do so. This passage shows that this participant is shouting on paper (although the interpretation of !?!%@#! is less clear).

5.1.6 Disability Issues

Disabled prisoners are entitled to protection under the Disability Discrimination Act, later replaced by the Disability and the Equality Act in 2010. Specifically within prisons PSO 2855, previously outlined, also places a duty on prisons to make adjustments to accommodate disabled people. Participants representing 75 prisons in England participated in this study. They reported a wide range of standards of accommodation. Although a few prisons offered modern facilities, most represented in this chapter, were older prison estate which was not designed with disabled access in mind.

- Inaccessible prison estate

One male validation group participant spoke about his frustration with prison estate which was not equipped, he felt, to house people with mobility issues.

The need for help with equipment and medication was another ubiquitous theme amongst participants. A few participants stated in letters that they felt this was in breach of Disability Discrimination legislation. They were clearly right in this. Two female correspondents were particularly well informed, and reported having successfully challenged such discrimination at their own prisons.

One female correspondent spoke about her arrival at her current prison, only to be left waiting for hours in reception whilst the prison staff decided whether they would allow her to stay due to her disability. She recounted having initially been told that she would have to go back to her previous prison. Refusing this, she argued that she “had earned the right to stay”, and the prison had “better make the necessary changes” to accommodate her. Despite being confined to her bedroom for several weeks whilst work took place to enable her to get around in her wheelchair, she won the argument and was now pleased with current arrangements.

Some participants were aware of their rights under the Disability Discrimination legislation, and three participant correspondents had effectively challenged a lack of provision at their current establishment. A further male focus group member said that he did not believe a large numbers of disabled prisoners were “genuinely disabled”, particularly “wheelchair users”. His view was nevertheless challenged by other focus group participants, who said this was not the case, and the prison population was growing increasingly sick, frail and disabled. This exchange illustrated one of the strengths of focus groups as an effective methodology. Participant challenge on this issue ensured that the research was not swayed inappropriately by the views of a single participant. A number of the group participants present were themselves wheelchair users, and their unhappiness with this comment was obvious. Thus, the debates concerning disability issues in the focus group were useful data for this work.

5.1.7 Dispensary Opening Times

- Dispensary opening times

Difficulty in accessing medication from the prison pharmacy was another issue identified within this study. One male correspondent who had experienced mental health issues for 27 years, and had finally been stabilised, spoke about working out of the prison and not getting back until 8 p.m. He said:

I told them I was working out of the prison and my tablets were there to be picked up. But they told me to come back on Tuesday knowing full well I had to be five and a half days without my tablets... I suffered a blackout

which in turn resulted in me having a panic attack. When I came to after the blackout I found to my horror that I had wet myself. This and the panic attack was a new thing which had never happened before, as a result of all this I ended up in a doctor's waiting room having absconded from my work party: male correspondent.

This participant went on to describe how the doctor refused to see him because he did not have his national health number with him. In these circumstances, it is difficult to understand why this man did not receive the care and compassion he needed. On the part of the GP, it could be an example of prejudice against prisoners, fear, lack of understanding, or multiple other issues. The inflexibility in both the prison and primary care system in this case, however, had a very tangible and unfortunate impact on the life of this sick individual. After handing himself in to the police, he was returned to closed conditions, and was then sentenced to an extra 18 months in prison.

- Unsuitable opening times

Flexibility of dispensary opening times at the prison was reported as being appreciated by patients, as they did not have to miss a day's pay. Participants felt strongly that dispensary opening times should be co-ordinated with the prison working day which was currently not the case. This created a situation in which patients, like the individual above, were unable to access their medication leading to stress and, in some cases, actual physical harm: "I was really scared and asked them what I would do if I had an attack in the night they told me don't call me, call an undertaker", said a female focus group participant who was asthmatic. This was a consistent theme across all participant groups, with the sole exception of the young person interviewee who said:

Um, I know that whenever I worked the nurse would come at feeding time when you're getting your dinner or get you out your cells the lads who needed it and would give out medicine from a trolley. I never had a problem myself. They had like a locked cabinet it was locked with security. I'm not sure if they carried paracetamol.

Adult participant comments on this subject are numerous; an adult comment considered to typify this issue is included below:

You were supposed to line up at 8.15 am and it took 15 minutes to get there. There would be about 30 people queuing for dispensary, so 15 minutes with a half hour queue and we would then get nicked for being late at work: female focus group.

5.1.8 Drug Misuse

In this theme, the focus is on drug use and addiction in prison. Ten wide-ranging sub-themes were identified demonstrating the negative impact on participants' health, safety and emotional wellbeing. To summarise, the data suggests that attempts to care for, and provide medication for this patient group are hampered by the addicted prisoners' fears regarding the prison drug sub-culture. This is exemplified and analysed to follow:

- Addiction issues

Participants felt strongly that prisons were abundant with drugs and those addicted to them. This finding supports the work of Fazel *et al.* (2005). Furthermore, one focus group participant commented that she believed drug abuse had led her into a life of crime, supporting national statistics explaining drug-related crime (The Information Centre for Health and Social Care, 2010). Thus, this research reflects certain facets of the existent literature, whilst also contributing to the field in a novel sense with its focus on equivalence.

A senior member of the Independent Monitoring Board (IMB) commented that she believed the failure of prison authorities to recognise the extent of drug addiction in English prisons prevented the development of appropriate healthcare facilities for this group. This point is illustrated in this female focus group member's quotation: "You'll never have a smooth running of health because everyone in here is drug dependent".

The IMB member felt strongly that prison healthcare should focus on the needs of addicts, and should create effective services to deal with both the physical and psychological damages that addiction inflicts on individuals. This, she argued, should include alcohol as well as drug misuse.

The widespread availability of illegal drugs was also a consistent theme in correspondent letters. Sometimes comments related to entire establishments,

as in the case of “they sent me to a prison full of drugs” and others, would speak about specific landings within prisons where the drugs were widely known to be available. Participants also raised related matters regarding the type of drug/treatment available, illustrated by this male correspondent’s quote: “Meth’s far more dangerous than heroin – if you can get off Meth, it’s so hard to. Substitute Meth and give heroin – it’s [*sic*] cheaper”.

This quotation would suggest that this participant is appealing for a different detoxification route as he is proposing that methadone is more addictive than heroin. Therefore, methadone is conceptualised by this prisoner as merely an expensive substitute for heroin, rather than an effective route to cure. Experiential literature about prisoners’ attitudes towards their drug/s of choice is difficult to locate. Studies largely focus instead on drug use *per se* or health and offending behaviour (Datesman and Cales, 1983; Joseph, 2006; Roberts *et al.*, 2007; Stewart, 2009). Zule and Desmond (1998) did, however, investigate limited aspects of prisoners’ attitudes towards addictive drugs, including methadone. The authors identified that few of their 61 participants displayed negative attitudes toward methadone. Positive attitudes were reported from those participants who had previously been successfully treated themselves, or had watched others also detoxifying on this drug. These findings, although somewhat dated now, oppose the views expressed by the male correspondent in this thesis suggesting a need for additional research in this area.

More recently, Carlin (2005) explored the staff and prisoners’ views to methadone maintenance in Mountjoy Male Prison, Republic of Ireland. This study had valuable implications for treatment with this drug, as both staff and prisoners expressed negative views about the manner in which it was dispensed and the purpose for giving it. The widely held perception amongst prisoners was that it was given to serve a latent function to control prisoners and maintain prison discipline. Were this to be the case, there are questions to be asked about the underpinning ethical framework for such programmes.

- Delays in prescribing

Experiencing delays in receiving prescribed drugs was also reported. A reason cited by prisons for refusing many medications was that these

interfered with prison required drug testing. Thus, there is, here, an issue between the prison regime and the NHS provision of healthcare. Indeed, “it is clear that, in many ways, mental health service provision and the criminal justice system exist in parallel universes” (Brooker and Birmingham, 2009, p. 3). One prisoner complained that:

I do not find that reason enough to stop prescribing to patients whom obviously need strong pain relief. It is illegal to tell a doctor what he must prescribe, and so if prison doctors are advised not to prescribe opiate based painkillers, then they are not acting in a professional manner, which is in breach of the law: male correspondent.

Further to this delay issue, the nature of specifically interested staff is salient. For example, a prison Governor spoke about the need for specialist staff with an interest in treating people with drug addiction. This, he felt, would ensure healthcare worked with the patient to make certain that the right treatment/medication was provided, based on individual assessment and requirement. Therefore, a link appears here between the prescription of prison-acceptable medication and the existence of interested/concerned healthcare staff.

- Detoxification *cold turkey* prison entry

Another consistent theme in participants’ letters was detoxification *cold turkey* defined as (the sudden and complete withdrawal of often illegal drugs without medication), and the problems this caused for prisoners:

I’ve seen guys try to take there [sic] own live due to DETOX [original emphasi] cold turkey that’s not right are you aware that between 6 & 8 [sic] inmates took they own life at X, but you will need to ask X head of healthcare why: male correspondent.

This issue was narrated often by participants, and their feelings regarding the prisons’ management of detoxification was criticised frequently and vehemently. This happened at a time when the Integrated Drug Treatment System (IDTS) for Prisons had been implemented in England. Key amongst the IDTS’ objectives was intensive provision of the CARAT Service for the first 28 days of imprisonment. Further, it was intended to improve opiate stabilisation for addicted prisoners and issue a greater number of maintenance prescriptions.

This work does not possess the data to debate the actual number of prisoners in England that are affected by detoxification *cold turkey* at any one time, or whether or not they fall outside of those participating in the IDTS. It would be fair to speculate, however, that the high number of addicted prisoners makes it likely that this remains an issue for HM Prison Service. Both the literature and this study's data depict a prisoner population with extensive substance misuse healthcare needs. Moreover, this study found that this is a regular occurrence in the prison environment, which causes considerable stress for those witnessing this practice in others, and thus generates fear regarding a similar fate themselves. The young person interviewee commented:

I wasn't a massive drug user. I used to smoke some weed and before I came in I just started snorting some cocaine. There are programmes and a lot of the lads are addicted to heroin and I'm trying to think how they were getting off the drug. I'm not sure they got methadone. I think they just went cold turkey.

This quotation suggests detoxification *cold turkey* is also present in young offender institutes.

- Detoxification programme had reverse effect on prisoner medication

The impact of detoxification programmes were reported to have other troubling effects. One female correspondent cited medication being rendered ineffective due to the detoxification regime leading to a bone infection, and in this extreme case, leading to limb amputation:

The prison told me the hospital doctor said that they could not give those painkillers here in prison. The long and the short of my story is this I was left with an infection for a year that spread to my bone and eat [sic] away my hip. I spent 5 [sic] months in hospital this year on a bone infection unit and lost my hip.

As this comment was made by a female correspondent, it was not possible to determine whether the bone infection had been caused by conflicting detoxification medication, or arose instead because the prison was not permitted to prescribe antibiotics of sufficient strength. It is also a possibility that this was an example of medical negligence.

- Drug threat to stay clean

Participants' concerns fell into two main areas. The first of these related to participant's fear about being housed next to prisoners who would lead them back into substance misuse, once they had become clean inside. The second issue related to fear of personal attack as a result of being located in close proximity to people who had drug related issues on the outside.

After years of heroin abuse I felt stabilised for the first time and optimistic about my future and did not feel the need to use heroin at all, Subutex is also an opiate blocker, when I arrived here at HMP X they immediately placed me on detoxification program [sic] and reduced me off Subutex and then allocated me to a wing where it was full of heroin: male correspondent.

This participant narrates being placed on a wing with men he had known pre-imprisonment, and had abused with pre-offence. He was fearful for his physical safety in this environment. This issue may suggest that challenging the contemporary contraband set-up of the supply and use of drugs in prison engenders hostility in other prisoners:

I explained to medical staff and allocations staff on my admission to prison that I did not want to be transferred to either X or X prison due to the fact I had enemies there (over the drug issue mentioned). The NHS system has let me slip through the net. Please help me. No one knows the pain I feel, but me: male correspondent.

This research demonstrates that the housing situation and location concerns regarding detoxification, and recently *clean* prisoners are current problems for HM Prison Service. Notably, the threat of drug-related victimisation is a neglected area in academic research. The problem regarding substance misuse in prisons requires joint working between the prison and health systems, and also urgent attention if required, as the current level of prison overcrowding can only exacerbate it.

Prisoner victimisation is important, however, an inability to control the environment is a significant factor (O'Donnell and Edgar,1999). Lahm's (2008) call for better tools to identify those prisoners at risk from attack could be helpful for these vulnerable individuals.

- Holistic care (lack of)

An example of a positive approach to healthcare for drug addicted patients is illustrated below:

Our healthcare forum recently managed a random drug testing unit, 200 prisoners tested 26 positive which is below average. Treatment for people with drug misuse issues is approached by looking at the whole person: male focus group.

In this case, the male focus group participant spoke in favour of the holistic approach his current prison had adopted. He explained that, by openly acknowledging many patients in the prison were addicts, treatment programmes were tailored to combat the range of health difficulties such as malnutrition, rotten gums, tooth decay and blood borne viruses. In his opinion, holistic care stood a far better chance of success as it was based on a realistic appraisal of the individual's current health status and treatment needs. As a life prisoner, with over 20 years experience inside, this was narrated as uncommon in English prisons. This is not particularly encouraging given the holistic nature of the Public Health Agenda recommended for English prisons, which served as the theoretical framework for Chapter Two.

One male validation group participant complained that prison healthcare fails to treat the whole person, and only looks at isolated symptoms instead. He felt that this was missing an opportunity to provide more effective healthcare and treatment. Holistic care in the wider NHS is generally used to refer to complementary and alternative medicine. This participant, however, did not appear to be using the term to refer to these wider treatments. Instead, his concerns appeared to relate to his experience of the episodic and issue specific nature of his condition, without reference to his wider health issues. This participant appeared to be in his late 60s, extremely slight in stature and seemed to be unwell.

Although the practice highlighted here is poor, it may not necessarily be inequitable with the wider experience of NHS patients in the community where a number of academics advocate the need to take a *whole patient* approach also for a range of conditions (Tasman and Rovner, 2004). For those patients with cancer, the necessity to detect the signs of psychological distress and

provide a range of appropriate treatment is particularly strongly advocated (Fitch, 2003).

- Inappropriate prescribing

The male focus group participants reported they had experience of prisoners being prescribed methadone for toothache. One participant laughed commenting that prisoners “come in with toothache and go out with a habit”.

Three male correspondents and a male focus group participant similarly described being prescribed methadone for toothache. On one occasion, the patient said he had not previously had a drug habit. Each of the participants who identified with this issue resided in a different prison, suggesting that this practice may be widespread. When later discussed with a Head of Healthcare interviewee, this practice was disputed. The staff member said that she did not believe the practice took place and if it did, it was in her opinion “highly unethical”.

One patient here was prescribed methadone for dentistry problems. He had never experienced opiate based painkillers and paracetamol would have been sufficient: male correspondent.

- Positive drug test and refusal to otherwise treat

One male correspondent with long standing ill health reported being refused his regular medication because he had tested positive for Subutex (Subutex, or Buprenorphine, is a long-acting opiate similar to codeine, heroin, and morphine, and is a prescription medication used to treat narcotic additions and dependence). This is particularly concerning, as Webster *et al.* (2005) found that prisoners fail to seek medical attention until they are very sick indeed to avoid detection of their underlying drug use. The failure to prescribe reported here could, therefore, have been deleterious to his health.

What the nurse told me was we don't treat drug addiction because it is self inflicted and there aren't enough drugs in this prison to get addicted! So now I'm not being treated at all: male correspondent.

He said that, when he asked whether they would help with his drug problem instead, he was also told no.

Thus, to end this sub-section, it is worth reflecting again on the aforementioned nature of holistic care. This particular prisoner experienced substance misuse issues alongside physical health needs. For this patient, therefore, an approach that addressed “all” his wellbeing and health requirements was arguably required. In the prison setting, there appears to be a lack of consideration of individual prisoners as there are often many, disparate issues that necessitate joint working between different NHS clinicians and prison staff.

5.1.9 External Support

The sub-themes identified here fall into two broad strands: firstly, prisoners’ concerns for family members and, secondly, the difficulties prisoners face when trying to access external professional support. Both issues are analysed below, and portray the challenges to imprisoned patients when desirable, or necessary, to interact with the external community.

- Concern for family member

I have a daughter called X who is nearly six years old, since I have been in prison my daughter has been physically and sexually abused... and has also self mutilated all of this being down to her traumatic upbringing by her mother: male correspondent.

In this case, the male participant said that his own health was suffering due to his worries regarding his daughter’s distress. As a father expressing concern for his child, this quotation was unique in this study. He was the sole male to raise such concerns. In contrast, the women participants spoke openly and often regarding their anxieties about family members, mainly children. In all cases, participants raising family issues were serving longer-term or life-sentences. One female correspondent said that concern about the care provided for their children led to increased frustration and anxiety. For women, these issues are widely reported in the literature (Dodge and Pogrebin, 2001; Edge, 2006; Hutchinson *et al.*, 2008; Jiang and Winfree Jr., 2006; Kolman, 1983). For men, however, this issue has received little academic interest.

- Lack of appropriate adult

One male correspondent complained “There’s generally a lack of appropriate adults in the prison system”. This was also an issue raised by a Magistrate. He complained that although facilities for young people were generally good, there is a lack of provision for adults. This resulted, he said, in serious delays in the criminal justice system for vulnerable adults who required this support and injustice for those who were not supported.

This practice is possibly also in breach of the *Police and Criminal Evidence Act 1984*, introduced as part of the policing reforms at that time. This Act entitles young persons and vulnerable adults (people with learning difficulties, mental illness or literacy problems) to the support of a parent, guardian or social worker if they are searched, questioned or detained in custody.

The prison population, as demonstrated in Chapter Two, is formed largely of these vulnerable individuals. The plight of the learning disabled was aptly demonstrated by Bradley (2009). Numerous academics have also highlighted the complex ill health and intellectual challenges prevalent amongst the imprisoned. These include: Cashin and Newman (2009) who found that people with autism are unsupported and over-represented in the criminal justice system, and similarly Turner (2000) for those with an intellectual disability, Hayward *et al.* (2008) for people with poor social problem solving and intellectual abilities, MacDonald (2006) highlighting the vulnerability of the young person population and Baroness Corston (Home Office, 2007) who drew attention to the poor treatment of women.

For individuals with mental ill health, a powerful body of literature likewise highlighted the vulnerable nature of this community. Ramsbotham (1996) is cited here as an example of seminal work which represents the views of many.

Thus, considered together as a representative sample of the appropriate literature, these works support Shaw’s (2007) argument that, given society’s vulnerable are being inappropriately imprisoned, the lack of appropriate adult provision is a scandal.

- In-reach unavailable

The lack of availability of prison proactive mental health provision termed *in-reach* was another consistent issue within this theme. The in-reach teams in prisons provide the secondary level mental healthcare. Participants compared their differing experience across several prisons, and commonly expressed that prison in-reach availability was highly variable, supporting Brooker *et al.*'s (2005) findings. In many establishments, participants reported that this could not be accessed despite acute need for support as the quotation below illustrates:

I do suffer a history of self harm and I am at risk from certain prisoners here, as I refused to bring drugs into this establishment and was threatened to the point of running away from my place of residence which lead to me being recalled for not residing where I was supposed to. I have been taking Zisplin now in this establishment but I'm still depressed. Because of the risk to myself from other prisoners I made applications to my personal officer and to the Governor but to no avail I have also made application to 'In Reach' but to no avail as yet: male correspondent.

It was not uncommon for participants to say that they had waited months for service provision, or, in other cases, for the service to be refused, or unavailable.

- Lack of key worker

Participants similarly expressed difficulty regarding access to key workers. As with the in-reach worker issues above, key worker availability was reported to vary widely. The urgent requirement some participants had for this support is illustrated in the quotation below:

I was assaulted by my in-laws this assault caused me great distress and triggered memories of 20 years of child abuse by my father. I had a nervous breakdown and was... I popped all my anti-depressants and painkiller tablets (3 months worth) ready to overdose and die. I was re-admitted to X Psychiatric Hospital. They stabilised me despite me begging them not to discharge me they did. I asked for a key worker. To no avail: male correspondent.

- Poor solicitor damaging mental health.

Women focus group participants were often hostile about the support provided by solicitors. Two women said that, during their time on remand, they had experienced a poor service. Another participant said that the worst part of her prison journey was her time liaising with her solicitor whilst on remand. She vividly recounted the stress she had suffered during their association, and felt this had caused her long-term health damage. Her solicitor, in her opinion, had provided little useful information, and had given poor advice. As a life prisoner, this participant had now entered her second decade of imprisonment, and said her poor experience remained vivid and painful.

The worst part, she recounted, was being unaware of what would happen to her during the remand period, and the potential impact her sentence could have on her family. These high levels of stress for remand prisoners have long been recognised by the academic community (Harding and Zimmermann, 1989). The quote below exemplifies this link between experienced health and perceived legal advice/interactions:

The solicitors appointed by the court of appeal are not responding to my letters or visiting me. I'm getting very poor legal representation regarding my appeal and my health has suffered: male correspondent.

- Prisoner attitude towards external provision

Social workers were another cohort of external supporters that attracted hostile participant opinion. Unlike prison healthcare staff highlighted as being in need of professional practice improvement in *The Future Organisation and Delivery of Prison Health Care* (Joint Prison and National Health Service Executive Working Group, 1999) and (Department of Health, 2008), prison social workers have received no such attention. The participant's experience in relation to this staff group suggests that this is a matter requiring urgent attention. The quotation below belongs to a Male Focus Group member who shook his head as he spoke about not wishing to get involved with "them". More generally, participants described avoiding social workers if they could. This was not always possible, however, and one male correspondent

commented “Social workers are do-gooders, we’re reluctant to get involved with those people”.

- Social worker unavailable

For some, contact with social workers was unavoidable. Below, this participant required social worker accompaniment for his appointment at a gender-reassignment clinic, saying “I did not find out till the day of my appointment that my social worker was unavailable”.

The social worker’s last minute lack of availability resulted in this participant being pushed to the back of the clinic’s waiting list. This, she said, had resulted in a further six months delay in treatment.

Prison social work is a further area which has also received little academic interest in England. American studies are more prevalent, although these have a tendency to concentrate on older prisoners’ issues, such as Snyder *et al.* (2009). The chaotic lifestyle of many prisoners leading up to their incarceration is likely to mean that any prior exposure to social workers would have been in traumatic circumstances. Thus, the notion of social work and its practice in the prison environment is ripe for future research and development. Notably, any such work should include prisoners’ perceptions and desires regarding these services since, at present, these workers and services are not portrayed as beneficial.

5.1.10 Healthcare facilities

Thirteen sub-themes were identified here. These varied considerably, some highlighting gaps in the availability of basic services, others showing serious concerns regarding the standards of cleanliness in women’s prisons. This varies from basic GP/nurse-led prison primary care services, to the more complex facilities located in prison hospital wings.

- Good service provided

The comment below is positive about healthcare in the participant’s current prison. In this case, the female focus group participant had experienced poor

healthcare provision for over a decade in a number of women's prisons. She spoke positively regarding the difference that good healthcare provision could make to a patient's experience. Thus, she had developed a high regard for current provision "got no problems with healthcare here. Not usually the case". She also added: "Healthcare here are much more relaxed and willing to help people in here work with everyone, in other prisons they don't".

Male focus group participants were also complimentary about their current prison, and said it was very unusual in their long experience of imprisonment. Group participants said they had seen "big changes in provision in the past 18 months" at their current prison. This was due to "proper management and a widespread change of staff".

These comments are encouraging and demonstrate that, in some prisons at least, the quality of staff is of high standard. The challenge for the agenda is to raise everyone to the level of the best.

- Improved facilities

One participating prison was working towards its own purpose-built facilities for healthcare, with de-fibrillation treatments and staff trained to use the equipment if required. The Governor strongly felt that it was necessary to create such amenities, as it was extremely complex and expensive to treat patients externally in hospitals.

However, women in the focus group were critical of the standard of cleanliness in prison, including healthcare areas. They suggested there would be a limit to the more specialist treatment that could be provided, if conditions did not improve significantly.

- Mental health facilities required

A belief that mentally ill prisoners should be in hospital, rather than prison, was widespread amongst participants. Participants were acutely aware of the lack of appropriate provision, and spoke of the suffering they witnessed. This

supports previous academic opinion on this matter (Bradley, 2009; Lurigio, 2002; Ramsbotham, 1996; Reed, 2003; Shaw *et al.*, 2003).

One female in the focus group said that she felt it was no coincidence that all of the mentally ill women she knew, “which was a lot”, had suffered sexual abuse in the past. This participant’s belief also supports Moran and Peterman’s (1989) previous research in this area. In the absence of effective mental health services, another female focus group member said, many women fall back on coping strategies they know best. This, she had found, was usually self-harm. This issue was endorsed by the young person interviewee. He described how other young people, when stressed, coped by cutting themselves. He believed that this practice was “despised” by prison staff who referred to the individuals as “cutters”. “On occasions”, he said, “they would sometimes taunt” the distressed young people and say “go cut yourself”. A prison healthcare lead also commented:

Quite a few inmates we get here should be in either NHS special hospitals due to their problems, and often have to put up with all sorts of abuse and should not be here at all but what can the prison service do if the courts send them in prison instead of the right places, but as you know there aren’t many proper hospitals for these ill people:
Prison Healthcare Lead.

Appearing sad and hopeless in the face of this, she concluded that it was extremely difficult to properly care for such patients, without the appropriate facilities, but that she “always did her best for them regardless”.

- No access to palliative care

The lack of amenities for the dying was another issue identified here. During the validation group, one patient from the wing was receiving palliative care in a local hospital. The group spoke of the difficulty prison healthcare faced when trying to provide palliative care in a setting which was not designed for this. Different views were expressed amongst participants about whether people should die behind prison walls. Some said it was wrong and that people should be released to die in the community. Others said that many prisoners had nowhere to go to, and would, therefore, rather die inside with their friends and people who had been caring for them.

One prison Governor spoke of his frustration of having to try to accommodate a dying prisoner in a cell in which:

[you] Couldn't swing a cat... how can I care for this man appropriately in a way that affords him dignity and respect. I've got nowhere to put a syringe-driver, wheelchair or a hoist. The hospital wants its bed back and he's sat with uniformed officers for the last few weeks of his life on a ward. I've tried to see if he can be accommodated in a local hospice and I'll put officers on duty at his bedside out of uniform if they'll let me.

One male focus group participant spoke about the close bond which develops over time between prisoners, and how difficult they find it when they become aware someone is going to die. This was mainly the case if they were likely to have to watch them do so. Another focus group member expressed fear that someone would collapse in front of him and he would be powerless to do anything to save them. He said he had administered the “kiss of life” in similar circumstances once but, despite this, he witnessed a man die before healthcare staff could reach him.

Another validation group member spoke regarding the “dreadful” sense of loss he felt when someone he was close to died, and how difficult it was on their landing when this happened.

The lack of self-help groups was also raised as an issue by a male correspondent. This participant complained: “lack of one to one work and support no self help groups or floating support”.

A patient’s inability to work proactively on their own issues was endorsed by a male validation group member. He argued that this limited his choice and was inequitable with patient experience on the outside. Another validation participant suggested that prisoners should be allowed to sign a disclaimer to say they would not sue. This, he considered would enable healthcare staff to “provide more holistic care”.

- No Well-Woman Clinic

The variable nature of healthcare facilities was also reported by this study's participants. Long-serving prisoners in the women's focus group said their overall experience of healthcare in prisons was "generally bad". One participant complained about the lack of a well-woman clinic saying that the majority of incarcerated women "for some reason have been sexually abused. A well-woman clinic is mandatory!" This assertion supports previous academic research which identifies the high prevalence of sexual abuse and victimization amongst imprisoned women (Fine, 1992; Moss, 2003). This has been particularly evidenced in the USA (Human Rights Watch, 1996).

- No translation facilities

This study identified an urgent need for translation facilities. One healthcare lead cited a prison in which she had previously worked, where she said over 60% of inmates were foreign nationals awaiting deportation. Translation there, she said, was almost non-existent apart from the support offered by voluntary sector black women prisoner's local service. When the service was unavailable there was nobody left to translate for the women. This issue was also highlighted by the young person interviewee who spoke of a young man in his institute who could not speak English. He commented that he had been placed in a cell with another young man who appeared to be from the same culture. He did not observe anyone translate for them during that period.

- Overcrowding

A lot of lads are just pretty much mute. There's no-one to talk to them and they can't speak English, but they'll have other lads in there. This lad had an offender in his cells and he seemed to be the same race and all that: male correspondent.

It is also important to consider what impact prison overcrowding is having on healthcare in prisons, as shown by previous studies (Collins, 2010; Prison Reform Trust, 2009b). A concern expressed by male validation group participants was the excess demand that overcrowding placed on prison healthcare resources. One group member complained bitterly that they had

doubled the size of the prison population in his jail, but complained that “we don’t have twice the number of doctors”.

- Unhygienic healthcare facilities

This study identified that it was not solely a lack of complex medical facilities which caused problems for prison healthcare. The basic lack of facilities to suture was also reported to cause considerable cost and inconvenience. Cleanliness, however, was cited as a considerable barrier to even the most basic form of treatment. Indeed, one female correspondent said that the hospital cells were filthy. She commented:

Prisoners, however ill, are expected to clean them but without the equipment needed to do so adequately. No toilet brush or Jay cloths etc. When I was admitted, I opened a locker drawer to find a green mouldy orange with maggots crawling out that disintegrated when touched and dead flies on the floor, bed and drawers. There was blood on the sheets, walls and floor and the smell of urine and the barred windows were locked and had no fumitory ventilation: female correspondent.

Another female correspondent said:

The hygiene standards would cause most matrons to have a fit and Florence Nightingale to turn in her grave. It’s difficult to believe that healthcare have ever been subject to a surprise inspection, but if they have been inspected the prison would have done a clean-up as they do when all outside visitors are expected: female correspondent.

Although this issue was only reported amongst female participants, there was an indication that hygiene was an unacknowledged issue in the male estate too. One prison officer, for example, reported that one man had to wash out his colostomy bag in the sink of his shared cell. He added that he had also known men to do so in the communal showers in other prisons, and that this practice was “quite common”.

The danger of Methicillin-resistant *Staphylococcus Aureus* (MRSA) and other acquired infection contagion arising from this in English prisons is an under-researched area. This issue has received serious academic attention, however in America, discussed previously in Chapter Three (Turabelidze et

al., 2006). In England the danger to individuals and the broader community arising from these infections is mainly concentrated on the hospital sector (The MRSA Working Group, 2008). Here, the Working Group identified that MRSA can be spread if “hand basins available may not be adequate to implement some infection control measures” (2008, p. 18).

Without doubt, the practice of washing out colostomy bags in the sink of a shared cell creates an *immediate and acute risk* of infection transmission. The Working Group warned that *Colstridium difficile*, another highly contagious and difficult bacterium to treat, could be spread easily through contact with “dirty surfaces” (2008, p.8). Without urgent action to highlight and prevent continuance of this practice, individuals will continue to become infected. Further, these dangerous conditions will be carried back into the general community upon release.

5.1.11 Healthcare Staff

17 sub-themes are identified here. From these the positive experiences regarding healthcare staff members represent only 3 of the analytical sub-themes. A caring attitude, a flexible staff attitude, and healthcare staff (improved quality) were highlighted. The other 14 sub-themes portrayed an overwhelming level of participant dissatisfaction with healthcare staff members.

The following sub-sections describe and analyse this data that refers to healthcare staff.

- Caring attitude of healthcare staff

Participants commonly reported a generally poor experience of healthcare treatment via healthcare staff, yet they did sometimes find themselves transferred to a prison at which the standards of care and treatment were perceived as excellent. Women focus group participants spoke of their relief and delight to occasionally come across this, and said that it was the attitude of staff which made such a difference. One woman commented that she (the Governor) “actually seems to like prisoners”. Specifically to healthcare

provision, Courtwright *et al.*, (2008) found that compassion was an essential element to effective care. The previous participant's comments would suggest that, more broadly, a caring staff member has other benefits to prisoners' wider emotional wellbeing too.

- Doctors' poor understanding and usage of English

Two male correspondents identified this issue to be of concern, and one of them is featured below:

The service offered by the healthcare at X is totally unacceptable and substandard treatment is offered by doctors from outside who have little grasp of the English language: male correspondent.

Correspondents in both cases felt the doctor's lack of adequate English exposed them to risk of inappropriate diagnosis and treatment. There is no literature detailing the prevalence of this dangerous professional practice in English prisons. More broadly, however, this issue was brought to the public attention when German doctor David Ubani administered his patient with a lethal dose of painkillers in May 2009. Despite the clear and continuing risk to patient health, the General Medical Council (GMC) are unable to prevent EU doctors from practising in England, as the duty to understand the language of the country in which they wish to practise resides with the clinician.

- Flexible staff attitude

In the female focus group, women spoke about the positive difference a flexible staff attitude can make. Again, the women said this was not common in their previous prisons. One woman said that, in her opinion, the attitude of prison staff reflected that of the governor. A respectful governor could make all the difference to their experience inside she felt "healthcare here are much more relaxed and willing to help people in here they help everyone, on other prisons they don't".

- Healthcare forming united front against patients

In contrast to the issue above, a male correspondent spoke regarding his experience of healthcare staff. This participant felt the healthcare staff intentionally were “lining up against him” when he attempted to access treatment. He spoke about the impossibility of obtaining any assistance at all when this happened, regardless of the severity of need.

- Healthcare staff - improved quality

The male focus group participants, however, spoke in favourable terms regarding the positive difference a healthcare member of staff who genuinely cared for the patients could make, and how this caring attitude towards prisoners could improve both the quality of healthcare experienced, and the overall attitude of healthcare staff towards offender health.

One male focus group participant reported that a prison psychologist had stopped the use of temporary staff and opted for qualified professionals only. This participant also highlighted that the prison had involved patients in the recruitment of new members of healthcare staff, and that services had notably improved as a result. The women in the focus group said that healthcare staff in their current prison: “don’t mind prisoners”. They felt this made a big difference to the treatment they received and their willingness to access it. Here, prisoners link their experiences of healthcare staff with caring attitudes to those clinicians who accept prisoners’ existence as the nature of their work with this population.

- Human rights violated by healthcare staff

Data from this research indicate that participants often believed their human rights had been violated by healthcare staff, as illustrated in this quotation: “I am presently pursuing an action order of the Human Rights Act in relation to Healthcare Service here”.

Two male correspondents and a female focus group participant spoke about taking, or threatening to take, legal action against their current prison for a perceived violation of their human rights.

- Inexperienced agency staff use

Male focus group participants highlighted the difficulty inexperienced agency staff faced when trying to work with prisoners. There was a consistent theme in letters from male participants who required experienced/expert care and attention.

Not many nurses want to work in the prison environment those who do are agency nurses whom have no real quality experience dealing or handling prisoner questions, or their needs: male focus group.

Without this expertise, patients felt they were failing to be treated effectively. In an extreme case, a male focus group member said there had been problems in his previous prison when inexperienced healthcare staff had inappropriately formed sexual relationships with inmates. This he reported had been brought to an abrupt end when the Governor became aware of it. Further, he posited that inexperienced staff are vulnerable to being conditioned by prisoners. Conditioning (as used here) refers to the process whereby prisoners insidiously change the behaviour of prison staff, particularly the vulnerable or inexperienced.

- Insufficient staff

Insufficient staff was also a concern to participants. One female focus group member complained bitterly that the lack of staff, particularly at night, led to prisoners being locked in their cells for extreme lengths of time. Staff, she said, would refuse to open cell doors regardless of the situation inside. This caused her extreme anxiety when her long-term condition flared up. She felt the current situation was unsafe for prisoners. This issue was also raised by the young person interviewee:

I think they need more staff. In X there were a lot of units and they only had a minimal number of staff and because you have all those different units it would have helped to have facilities on each wing.

- Lack of healthcare knowledge and understanding of complex medical issues

Considerable hostility towards nursing staff was narrated by participants during this study, outlining a general belief that nurses either blocked patients' access to doctors, or undermined the doctors' decisions "despite not being qualified to do so". Only one participant, a male validation group member defended nurses saying: "I don't know how they cope with some of them in here".

One male correspondent complained that the nurse "doesn't think my toe infection is important enough. She tries to be a dentist too, doctor and everything else you can think of". A further male correspondent said "different nurses tell you different things", with another commenting that "nurses are over-stretched and under resourced, making decisions that they are neither trained for nor resourced to do". This perception was strongly held in the validation group when one man reflected "people who don't know think they are medically trained". This was readily endorsed by the other group participants.

The *Nursing in Prisons Report* (Department of Health, 2000) built on an earlier report, namely *The Future Organisation of Prison Health Care* (Department of Health, 1999). It was thus determined that a prison healthcare team should possess "a range of qualifications and competencies suited to the health needs of prisoners" (Department of Health, 2000, p. 3). Participant comments above, however, suggest that prisoners, particularly long-term ones, were largely unaware of this. This is perhaps surprising when one considers that of the 2 million healthcare consultations with prisoners between April 1998 and March 1999 two thirds (1,557,482) were with a nurse or healthcare officer, only 27% (610,922) with a doctor and 9% (249,780) with a visiting NHS specialist (Department of Health, 2000). There are, at the very least, communication issues here which merit further investigation. It could also perhaps be considered that equity with the wider patient population had been achieved here for imprisoned patients. Ironically, they remain in part oblivious to it.

- Nurses undermining doctors' decisions

Four male correspondents expressed considerable hostility towards nurses, stating that they were deliberately blocking their access to doctors. There was extensive confusion about the role of prison nurses and the previous less skilled role of a healthcare officer:

I am serving a life sentence I have been here for nearly two years and within this time the healthcare has been a complete disaster. I am on the TC and we have a nurse who undermines and over rides the doctors [sic] decision: male correspondent.

- Patient's hostility towards healthcare staff

The lack of sympathy expressed towards healthcare staff became apparent when it was first encountered during the validation group. Here, a participant discussing his condition, suddenly thought about the Head of Healthcare and described her as "little Miss Prim!" The words were uttered angrily.

- Poor staff attitude and prejudice

Participants expressed a belief that they were discriminated against because they possessed the label *prisoner*. One male correspondent complained bitterly that doctors should not remain in prisons too long, because they lose the doctor-patient relationship, and develop a doctor-prisoner one instead. One male focus group participant said he could not be disrespectful in return, or it would result in him "being nicked". This is an interesting reflection which relates to the institutionalisation debate in the literature. As such, it falls outside the remit of this study but is worthy of comment nonetheless.

A male correspondent said that healthcare staff have:

[a] generally disrespectful attitude towards prisoners – all prisoners deserve whatever they get and are not worthy of decent healthcare or compassion when ill: male correspondent.

The perception amongst participants, that imprisoned patients suffered widespread prejudice, was also reported. This issue was raised in four male participant letters in relation to the hospital treatment they received for their

conditions. A further male correspondent also raised this issue in relation to prison GPs.

At HMP X one patient said the GP on sick parade just sat behind a desk wearing his coat... this was due to a poor attitude towards patients who are in prison.

In this case, the participant considered that the above behaviour demonstrated a “lack of respect”. This was another commonly used expression in this study. One participating Governor also commented that respect was something which he considered to be fundamental to effective working with prisoners. The prison service he added, had done much to improve in recent years, but pockets of poor practice were still widespread and prisoners were acutely aware of this. Regarding his personal practice, he now referred to prisoners as Mr X (rather than number or last name as was common practice), and had found that this had led to an improvement in both communication and attitude. This example of variability in professional practice, of both healthcare and wider prison staff, contrasts with the commitments made in *The Future Organisation of Prison Healthcare* (Joint Prison Service and National Health Service Executive Working Group, 1999).

- Rapid doctor turnover

The rapid turnover of staff in many prisons was a source of irritation for participants. One male correspondent said “here we have a system that changes these doctors every few weeks. They have no knowledge of your medical history”.

The widespread use of locums was complained about by two further male correspondents. The contradictory opinions on this point highlight the complexity of trying to provide healthcare services in secure settings which ought to be experienced as acceptable by all imprisoned patients.

- Staff stopping medication

This was a consistent issue raised. Participant correspondents, validation group, and male and female focus group participants all cited examples of healthcare staff stopping previously prescribed medication. One male

correspondent reported having returned from a post-operative hospital appointment with his medication, “only to have it removed by the staff on the gate”. For some, this practice proved extremely dangerous and almost ended in loss of life, aptly illustrated by the testimony of the 19 year old below:

When I was up at court I was seen by a CPN who had great concern for my well being since coming into police custody, so I was put on constant obs [observation] and I received all the medication I was getting in hospital. The nurse rang the jail and sent an urgent fax explaining that I have to have my meds. I received only sleeping tablets on my first night and received no anti depressants, this later resulted in my trying to commit suicide by slitting my wrists and taking an overdose by taking a pod mates tablets: male correspondent.

Participants felt specifically aggrieved if the medication involved had been prescribed by a mental health, or other specialist clinician. Reasons for stopping medication were reported to range widely and included drug-free prisons not allowing opiate-based medication on the premises, healthcare staff refusing to believe a patient’s word that they had been prescribed the medication in the absence of patient records, and concern that patients would sell the medication to others. When asked whether PCTs condoned such behaviour, one PCT Commissioning Lead claimed to be “astonished” to hear of such a practice. She thought it was “at best highly unethical and could even be illegal”.

A review of local healthcare policy supported imprisoned patients’ beliefs that NHS clinicians were instructed not to prescribe opiate-based medication for prisoners. A prison officer also commented that medication “along with anything else they can get their hands on is currency in prison”.

5.1.12 Medical Records

The lack of accurate or, indeed, any medical records for imprisoned patients was also raised by participants. In some cases this was the result of participants’ poor use of healthcare services in the community prior to imprisonment. More commonly, however, the absence of electronic patient records caused problems. The system highlighted relies instead on hastily compiled paper medical records initiated when the patient enters prison. For those prisoners transferred between establishments, paper records,

participants' claimed, lagged behind, creating a health and safety risk for the individuals concerned.

These issues, and those below, have achieved national recognition. During the fieldwork phase of this research, the Department of Health commissioned NHS Connecting for Health to deliver a national clinical IT system across the Prison Service in England. The system, TPP SystmOne Prison, was intended for national roll-out by December 2010 in line with the Offender Health Business Plan and strategic delivery plan for health and criminal justice.

- Hospital not forwarding on medical records

This interface between the prison and hospital healthcare was also reported to result in medical records being delayed between the establishments. In the absence of a compatible electronic patient records system, participants said they had to rely on test results and other records being transferred to the prison healthcare department. It was a common complaint amongst male participants that this frequently happened. In one case, a male correspondent complained that, some six months later, he still had not received his test results from a local hospital.

- Medical information not requested

There was also an indication that hospitals had not forwarded on test results, or staff at the prison had not communicated results to patients, causing them anxiety. In addition, other correspondents cited examples where staff had passed on details of follow-up appointments directly to patients, resulting in the later cancellation of the appointment once prison staff became aware of this. One female correspondent asserted that she had repeatedly been told her hospital had requested her medical records (detailing her long standing condition from her GP). When she later visited the doctor whilst on day release, she reported being told that over the period, not a single request had been made.

- No medical records system

This study also identified that the variable access to accurate patient records is considered another major barrier to patients accessing safe and effective healthcare in prison. One prison healthcare lead spoke of some prisons which refuse to accept people who did not have adequate records. Participants described a regime in which they moved rapidly around the prison system with what little medical record they may have had lagging behind them. One male focus group participant said:

They have no knowledge of your medical history and often rely on what you tell them what you have been on in the past, what medication you were/are on and such things. This occurs every time you attend as a new doctor is less aware of your past history than the previous one. I know for a fact this is not up to NHS standards for GPs.

One participant said that the medical record system is “generally bad”. This creates an increased risk for patients as it could lead to not receiving the correct medication and treatment.

- Unclear what happened to medical records

Another issue participants raised in relation to medical records was their confusion about what had happened to these documents. This was discussed by participants who had undergone hospital treatment in particular. The young person interviewee raised this issue and four male correspondents also complained that their medical records had gone missing. One of these participants reported he was still waiting to access his records six months after visiting hospital for medical tests.

5.1.13 Medication

Medication is another theme attracting strong participant opinion. Some 14 sub-themes were identified here, and similarly to the prison healthcare staff theme, participant opinion was overwhelmingly negative. This theme identified imprisoned patients living in constant pain and discomfort. Thus, it further highlights the strong influence prison governors have over the prescribing

regime in their establishment. This may lead to insufficient, or in some cases, a complete lack of clinically recorded treatment.

- Damage to health caused by incorrect medication

Two male correspondents and a male validation group member spoke about the difficulty they experienced when attempting to access insulin for their diabetes. One said that it was common practice for prisoners to stock-pile this medication for emergencies, as these were fairly frequent. A male correspondent also commented “before the change of staff I had to wait 5 weeks without insulin. I would have been nicked if they found out I was keeping my own stock”

- Delay in receiving prescribed medication

Participants frequently complained about difficulty accessing medication including those who had repeat prescriptions, as illustrated by the quotation below:

Never mind trying to access ‘health care’ (which is a misnomer – it should have ‘careless’ in there somewhere) I cannot even get my regular repeat prescription on time without any almighty battle each and every time they are due: male correspondent.

Participants reported that one of the main difficulties arose because prisoners generally were not allowed standard quantities of drugs because of the risk of abuse, or sale to others. This resulted in the need for frequent returns to the prison pharmacy for the required medication, and a perception on the part of patients that the system could not cope.

- Incorrect medication

Two male correspondents also repeated that patients try out each other’s medication in the belief that they had been prescribed incorrectly. Despite the attendant difficulties described, medication was still reported to be widely available on the landings.

Prison healthcare has learned that nanny state attitude of knowing best when they clearly do not if they did they would have given me anti-inflammatory

medication for inflamed pancreas not paracetamol. I discovered anti-inflammatory on the wing by trying someone else's [sic] medication which is a nickable offence: male correspondence.

- Medication being tampered with

Alteration to patients' previously prescribed medication was something participants repeatedly said they were unhappy with:

When I entered the room and asked for 600mg Gabapentin because the 100mg were not sufficient he informed me he is not giving anymore out and is cutting people down on that medication. Therefore he had made his decision before I came through the door. Following this he refers to physiotherapy notes stating 'your trapped nerve no longer gives you problems' classic example of negligence the second time in 5 minutes: male correspondent.

- Medication denied

Participants spoke of their inability to access effective or adequate treatment and their belief that their health would deteriorate. Another male participant correspondent commented: "When I came in here I had a body like a male Adonis, they have poisoned me and won't give me any medication".

- Medication thrown away

This wasteful practice was another issue of concern identified:

I believe we don't get proper medication in prison, if we miss our medication, they throw it away and we have to wait till the following day which is wrong, I speak for myself I have stopped taking it: male correspondent.

The issue was only raised by the participant above. It is not possible, therefore, to determine how widespread this practice is.

- Pain relief medication insufficient for need

Painkillers that were insufficient to alleviate chronic and acute pain were the most frequently reported medication problem. One female in the focus group disclosed that she was only prescribed Ibuprofen following abdominal surgery. Some patients spoke about being prescribed medication by their hospital

consultant, only to be told later, at their prison, that this would not be allowed due to the prison regime:

I had an operation under general anaesthetic for a testicular torsion and also had a camera inserted into my bladder to look for cancer. After coming around from a successful operation I was under considerable pain and as a result I was prescribed a strong opiate painkiller for 7 days. I was in hospital over night [sic] then upon my return I was told by the nurse I would not be receiving the medication I was prescribed by the hospital and I could take paracetamol every 4-6 hours I spend that night in tears because of the pain I was under and in the morning I saw the doctor and after a lengthy debate he still refused the appropriate painkillers. It wasn't until I ripped my trousers off and the dressing on my wound to reveal the state of my body that the doctor decided to give me codeine instead of paracetamol which was still inappropriate and didn't help!: male correspondent

Another male correspondent spoke of his agony after being prescribed Paracetamol following abdominal surgery. When he complained, he was simply offered Ibuprofen.

- Patients bullied to give medication to other prisoners

One discussion group member reported that vulnerable, older patients were likely to become the target of younger, fitter prisoners, and were either forced to surrender their medication, or have it stolen:

People get beaten up and their drugs get taken. One old man, struggling down stairs with his tray got tripped up by one of the lads deliberately. The bullying goes on all the time: male discussion group.

Such comments support previous academic research (Ireland *et al.*, 2009; Wolff and Shi, 2009).

- Patients selling medication

This study also identified that participants did not trust prison staff. Both male and female focus group participants said that prison staff did not trust prisoners either. Much of this arose, participants believed, because staff thought patients only wanted to access medication in order to either misuse it, or sell it. One said “in fairness, [to staff members] a lot do”. This mistrust was specifically related to medication and did not indicate a wider distrust of figures

in authority previously highlighted by Easteal (2001). Or, Howerton *et al*'s. (2007) distrust in services *per se* or Rosen's (1990) Jail Law suppositions.

One older male focus group participant said that older prisoners could be too ill to work resulting in a lack of pay and reliance on the basic prison weekly allowance of £2.50. He commented that prisoners relied on their weekly wage to buy cigarettes, toiletries and items of food to supplement their diet. Many older prisoners received no visitors or essential items from outside prison. Hence, faced with extreme hardship, many older prisoners had no option other than to sell their medication to other more prosperous prisoners. He also complained that this would then be misused and the health of the patient selling it would then deteriorate. The goods sold were often essential medication for heart conditions, or other serious health problems he believed. This practice appears to undermine local prescribing and patient treatment data.

- Previously prescribed medication denied

This matter relates specifically to the denial of medication which clinicians believe will interfere with the prison drug testing programmes.

I have been on Kapake medication for about 2 years because of the sever back pains I get, now that I have come into prison, one of the doctors here has said I can't have it because it interferes with their drug testing program [sic], but that is a lie, because in my previous jails, they used to send my urine to be screen tested, so they can see whether it is pharmaceuticals or illegal opiates and my results were always consistent with medication. I've never failed an MDT: male correspondent.

- Proactive treatment

Lack of access to proactive treatment was also an issue identified. A male validation group participant described what it was like to be on the landing when diarrhoea or other common illnesses were present. He said that he felt powerless to avoid catching "bugs", and believed access to "routine over the counter remedies" would prevent him from doing so. He remarked that the lack of availability of such items in prison was discriminatory.

This highlights the powerless state of the imprisoned who are required to take responsibility for their own health within the Public Health Agenda presented in Chapter Two.

Illnesses spread like wild fire in here... if I wasn't in prison I would be able to walk down to the chemist and purchase any over the counter medication: male validation group.

For participants, this experience could be considered to be both inequitable and harmful for their health. Ironically, however, this inequity may act as a form of protection as there is an emergent debate suggesting that *over the counter remedies* may in fact be putting patients' lives at risk (Mail Online, 13th April, 2010). Here it is argued that the Government's pushing of the *Self-care Agenda* was leading to pharmacists prescribing a range of complex medications for which they had insufficient training.

- Staff stopping medication

Prison healthcare staff would refuse previously prescribed medication citing prison security as the reason for this:

A lot of inmates who where [sic] seeing an NHS doctor outside and was on certain medication are not getting it my argument was we should have the same duty of care regardless of being in prison. The prison will say that for security reasons they cannot give out some medication the doctors are not employed by the prison service but by the NHS: male correspondent.

It was unclear what the security issues were in relation to the administration of medication. It was also impossible to determine whether the reported change in medication resulted in lower quality drugs and, therefore, an inequitable level of service for the patients involved.

- Sufficient medication

Only one participant said that she had been given sufficient medication for her needs. As a lifer, she had spent many years in prison and found the level of trust on the part of healthcare in her current establishment to be unprecedented. She commented: "X's is really nice and made sure I got the supply of my meds": female focus group.

- Vitamin drink denied

The issue of staff refusing health-related products was also raised by the male correspondent below:

I don't eat meat as I can't digest it but 4 weeks down the line I'm still waiting for my build up drinks the hospital as wrote to the prison saying to put me on them I seen the doctor in here he said the same but the manager says I can't have them I've heard it because it costs too much money but I seen a nurse the other day and she says they have been ordered then I seen one today and I told I'm not getting them so I've got some one [sic] who isn't a doctor telling me I can't have them I think the Healthcare in here is useless: male correspondent.

The young person interviewed also raised the issue of young people needing “build-up” drinks to help them to gain much-needed weight. The most commonly cited reason for prisoners being underweight was the effects of drug misuse.

5.1.14 Mental Health Issues

People with mental health issues are frequently a source of concern amongst sympathetic prisoners (Bradley, 2009; Ramsbotham, 1996; Shaw, 2007; Yorston, 2004). This theme demonstrates an acute awareness, amongst both men and women, that the prison environment is not the place for the mentally ill. Participants spoke about others whom they believed should be receiving hospital care as they were only housed in prison due to the lack of appropriate specialist facilities elsewhere. This supports Shaw's (2007) argument.

In contrast, however, the work of Prins (2010) featured previously, stated that a nuanced approach was required to explain this phenomena, as no direct link has yet been established with deinstitutionalisation.

- Mental health deteriorating in prison

There was considerable support for Bradley's (2009) report also. Here, participants reported being concerned about people with learning disabilities or mental health issues who could not access specialist treatment and said “they get worse inside, they really don't understand what's going on”.

A male correspondent commented:

I would like it to help me get my proper medication, anti-depressants, and let me know what I can do to stop bleeding... basically I've been dumped in prison through a lack of NHS Mental Health beds, and how I was ever passed as fit to be charged and detained needs questioning, one moment I need treatment and admission into hospital, then no beds, charged and arrested.

- Self harm

Widespread self harm was reported as an issue by the young person interviewee and female focus group participants. As previously highlighted, the women spoke about their perceived link between self harm, as a coping strategy, and childhood sexual abuse. This belief is also held by prison officers who participated in Short *et al.*'s. (2009) study. Here, the researchers found that women self harmed as a result of "imported factors" including a history of sexual abuse (Short *et al.*, 2009, p. 412).

In 2009, self harm amongst women prisoners was reported to have reached epidemic proportions having almost doubled in five years (Independent Online, June 27th, 2009). Here it was reported that one-in-three has suffered sexual abuse, and two thirds suffer from depression and other mental health conditions. The article asserted that 40% of sentenced women serve just three months or less, and Juliet Lyon the director of the Prison Reform Trust, commented "Women injure themselves repeatedly in prison because they are mostly in a terrible state: poor, scared and ill, hurting from painful separation from their children and detoxification from drugs and drink" (Independent Online, June 27th, 2009, p. 1).

5.1.15 Prison Environment

This matter concentrates on wider aspects of prison estate and differs from the healthcare facilities theme previously discussed. Participants spoke of their dissatisfaction with prison food, and opportunities to spend time exercising outdoors. Participants also described a world in which they move rapidly around the prison estate in England, and the impact this has on their relationships and emotional health.

- Exercise

This was an issue raised by discussion group participants. One group member spoke about the prison facilities having been closed due to health and safety issues. He stressed that people had not been out for months and had been unable to exercise “there’s no facilities for older prisoners to go outside here, it’s unsafe. We used to have the yard but it’s been closed down now”.

- Prison food

Prison food was also a source of criticism. This issue was raised by two male correspondents who also had diabetes and a member of the male validation group.

Prison is a very difficult environment to control diabetis [sic]. I’m now suffering from sight loss and also sensation in my limbs, prison food is the cause of this deterioration: male correspondent.

A member of the male focus group also raised this issue. He complained that the poor nutritional value of the food had an effect on his weight and long standing heart condition.

The food here, throughout the prison is unhealthy and mostly stodge, and in the hospital wing there was less choice than ever and had to be gobbled down in haste: male focus group.

This has the potential to undermine the implementation of the Public Health Agenda in prisons when considered in the context of other research findings. In one of the largest studies exploring women prisoners’ health in England and Wales, Plugge *et al.* (2006) found that, in prison, women’s activity levels remained sedentary. In 2010 the Prison Ombudsman concluded that poor food and stress are responsible for a rising number of deaths in UK prisons (Guardian Online, August 8th, 2010).

There has also been long term speculation in the literature that poor diet is linked to antisocial behaviour (Gesch *et al.*, 2002). Thus, considered together this powerful combination of poor nutrition and unhealthy lifestyles contradicts

several elements of the Public Health Framework required in English prisons and previously discussed in-depth in Chapter Two of this thesis.

5.1.16 Prison Hygiene

Only female participants raised concerns regarding what they perceived to be poor standards of prison hygiene, and the detrimental impact this had on their health. Unlike the unhygienic prison healthcare facilities sub-theme, these issues relate to the dirty conditions present elsewhere in prison. One female focus group member was particularly critical of prison kitchens. She described one occasion when she had a gastric illness, but was not granted time off. As a result, she claimed to have spent the day cooking interspersed with repeated trips outside into the prison yard to vomit. This narrated lack of prison hygiene representing a further novel finding of this research and, as such, is worthy of future research attention.

5.1.17 Prison Regulations

Prisons operate within a complex framework of regulation and rules. Many of these are prescribed through Prison Service Orders and Prison Service Instructions as previously discussed. This theme highlights the bureaucratic system within which prisons must operate. Participants describe a world of prison rules which at times, they argue, impede upon their healthcare needs and treatment requirements.

- Prison regime blocked access to care

The prison regime preventing effective treatment was a constant theme, both for correspondents and focus group participants. Of particular concern was the lack of escort availability, and also pharmacy opening hours which were out of synchronisation with the time prisoners returned from work. At other times, the regime was reported to obstruct acute need for medical care. The young person interviewee commented:

There was this guy though he ended up having appendicitis he ended up screaming behind the door in his cell. Obviously you can't see who it is but the guy was obviously in a lot of pain and in fact they didn't let

him out, I think they waited till the morning then they got him straight off to the hospital. That was really bad: young offender.

This participant then described how all the young people on his landing had to listen all night to him screaming in pain without anyone coming to his assistance. The reason for this, he thought, was the security risk due to low staff numbers at night, and medical staff having gone home. This memory was still present several months later.

He went on to say that the prison system could not be altered for emergencies once *lock down* (sudden closure of the prison due to significant concern) had taken place. This was raised previously by a member of the male validation group. He said he felt afraid that there would be a medical emergency and the ambulance crew would not be permitted entry to handle the situation. This state of affairs is clearly inequitable when compared to the experience of patients in the external community. It again demonstrates the complexity of providing healthcare, emergency or otherwise, in a secure environment.

5.1.18 Prison Staff

This theme relates to non-healthcare prison staff. Three sub-themes are identified, showing both positive and negative views about prison staff. A member of prison healthcare staff thought that prison staff are hostile towards her own staff group.

- Caring attitude of prison staff

When bullied, the young person interviewee reported having felt very well cared for by one prison guard. Females in the focus group also spoke about the difference caring members of staff could make. A couple of the women said that a good prison governor can make a profound difference to the prison environment. Female participants commented that being called by their first name made them feel like they were being treated with respect. This practice was not found in male prisons where the respectful term of address elsewhere described was Mr.

Those prison staff who displayed a caring attitude within this study are to be commended. It is important to recognise the severe pressure under which many are working and the unhelpful entrenched punitive attitudes of the wider prison culture. Between 2000 and 2006, there was an increase in the prison population in England of 24%, with an increase of only 9% in prison officers (House of Commons, 2009, p. 5). Frustrated officers were quoted within the same study saying that they did little other than to “warehouse” prisoners now in the face of the acute level of demand the mentally ill, in particular, placed on the prison service (House of Commons, 2009, p. 38). Whilst this does not excuse uncaring behaviour, the pressure experienced by prison staff must be acknowledged.

- Prison staff’s hostility towards healthcare staff

Prison healthcare staff believed prison staff were hostile towards them. One head of healthcare commented:

We’re near the bottom of the shoe as far as the prison staff are concerned. They stand around and read papers while we get attacked. We’ve been trying to do some work with them around swapping roles and developed a communications plan. We’re trying to win hearts and minds but it’s about getting systems and processes in place. We’re going to run an event: Head of Healthcare.

This person believed this to be a relatively new issue following the recent transfer of prison healthcare to NHS responsibility. At this point in this study, this was being experienced three years post-transfer to NHS responsibility. The Acting Head of Healthcare included above embedded the emergent underlying tension presented within the wider prison cultural context, saying:

The culture can be very, very abusive to the staff. We’re setting expectations within our [NHS] culture. Patients don’t have those boundaries on the outside so we set them out in a simple letter. Need to protect nurses and show respect, a united front with the prison staff would be a help. They think they can access things a bit better inside but they don’t...

With a heavy sigh, she finally said “culture doesn’t change overnight”. There is clearly a need highlighted here for these two services to work together for the benefits of imprisoned patients and, indeed for their own wellbeing.

- Uncaring prison staff

One woman, during the focus group discussion asked another participant whether she could remember the “dreadful healthcare staff” at their former prison. She commented “they don’t like prisoners, the treatment you get at X the dentist just ripped a tooth out and that was it”. The general opinion of the group was that prison staff “were bad”. They found great relief in an establishment where staff appeared to care.

5.1.19 Prison Sub-Cultures

Three sub-themes are identified for this theme. These highlight the hidden world of informal prison rules and protocols. Participants paint a vivid picture of their existence within a pervasive prisoner culture exerting a powerful influence over their daily lives. When describing the prison culture, participants frequently reverted to prison *Argot*, highlighting the distinct identity of this complex community and its hidden rules and behaviours.

- Compensation culture

Validation group participants spoke about a strong compensation culture amongst prisoners, and inmates “suing for anything they felt aggrieved about”, some doing so repeatedly (prisoners are entitled to free legal support throughout their sentence). This group felt that many used this facility to the full. Another group participant said that fear of being sued led to healthcare staff being overly cautious in their treatment. This led, he argued, to the “same old tried and tested treatments and prescribing being continually offered”.

Two male correspondents spoke regarding their direct experience of threatening the prison healthcare department with legal action, one after waiting five weeks for insulin, and another who had been attempting to access dental care for two and a half years. Other common reasons for seeking legal support amongst participants, was the refusal of access to the doctor, or to prescribe medication which the prisoner felt was needed.

- Prisoner culture

One participant in the validation group reported that he knew another prisoner who had Tuberculosis. The man, he said, was concealing this from all members of staff. It had left him feeling afraid for his own health, as he knew little about the condition, and was worried he could catch it.

There were clear examples of participants believing that staff saw them as a collective, since they were generally described jointly as “them”. One male focus group member said that this worked in reverse commenting that “we don’t tell them anything”. It was difficult to ascertain whether this was an example of O’Donnell and Edgar’s (1999) inmate solidarity theory, wider prison cultural issues (Glaser, 1967), or the lack of trust discussed previously.

The invisible world of unwritten rules in which prisoners exist became apparent during this study. Even the very young had an acute awareness of these:

[...] but if you have a bit of an attitude and there’s an officer you don’t get on with then they’re not going to be particularly helpful to you. I never really put a foot wrong in that place coz obviously they were the key to me being all right and if you show them a bit of respect it’s easier to live. It depends how you behave as to how they see you: young person interviewee.

When asked what would happen to young people who had difficulty understanding things, the young participant interviewee said “pretty much they just see those lads as bad guys the whole thing in prison is like that with officers being nasty to lads who just be cocky or disruptive”. This issue again supports Bradley’s (2009) report detailing the vulnerability of the learning disabled in prison.

5.1.20 Privacy

A lack of privacy is something frequently complained about by participants. This can result in their medical issues being known by other prisoners and wider prison staff. One validation group member spoke of prisoners going to great lengths to hide their medical condition from both prison and healthcare

staff. He described a sub-culture of deceit which he felt could be dangerous to both the patient and others with whom s/he came into contact.

- Letters read by prison staff

Two female focus group participants complained that letters they had written to this study in its earlier phase had been destroyed by prison staff. For some prisoners, those on stalking orders, for instance, the opening of mail is routine and expected. Other prisoners can expect mail to be opened as part of a random sampling procedure. Participants were critical that their complaint letters were being opened and read, thus alerting prison staff to confidential issues.

5.1.21 Social Care

Prisoners' need for social care provision emerged strongly during this study. Participants from the validation group, focus groups and discussion group all described an increasingly sick and ageing prison population which suffers from a lack of such services. Thus, prisoners said they had to step in themselves in order to provide support (highlighted previously in the carers theme). Without this care, one Head of Healthcare said, prisoners can find themselves housed on mother-and-baby units, or other unsuitable facilities. The lack of agreement about who should provide this much needed social care is also highlighted.

- Lack of social care

It was clear that there was a major gap in social care provision at the current time, illustrated in the quotation below:

A lot of what we're expected by prison staff to deliver in here is what you would call social care on the outside. I think the prison performs that function. We have a bunk bed issue as they don't have cot-sides, people get injured falling out of bed. We need a prison hoist but the prison refuses to provide one for the prisoner saying healthcare should provide it. The prison won't provide wheel chairs either and want healthcare to provide those also – so prisoners are isolated and can't get around the prison: Head of Prison Healthcare.

The lack of social care evident here is an interesting finding to this work. The increasing ill health and frailty of the prison population suggests that this

is likely to be increasingly widespread in English prisons and warrants attention.

- Older prisoners

Older participants in the male validation group said that they sometimes felt afraid of younger men in the prison. They said the young and strong would “barge their way around the prison”, and argued that older prisoners needed their own facilities. Validation group participants said that older prisoners tended to suffer from dementia, heart conditions, confusion, old age, fear, isolation, and thus “depended on other prisoners”. These views support a number of academic studies which have reported the prevalence of these conditions amongst the imprisoned population (e.g. Bradley, 2009; Braveman and Gruskin, 2003; Condon *et al.*, 2008; Fazel *et al.*, 2005; Hayward *et al.*, 2008; HM Inspectorate of Prisons Youth Justice Board, 2009; Moran and Peterman, 1989; Stewart, 2009; Yorston, 2004).

The reported dependence on other prisoners, however, relates to the *caring in prison* finding in this study and is previously unacknowledged.

- Sick and vulnerable prisoners

This study also found that issues of ill health were not confined to the older group above. The young also neglected their health, as the young person interviewee commented “I had other things on my mind out there”.

Addiction issues, lack of trust in professionals and underlying mental health problems were factors which female focus group participants felt led to ill health and unwillingness to access healthcare in the community.

5.1.22 Treatment

22 sub-themes were identified here, making it the most commonly debated topic within the data. The focus was on patients’ abilities to access effective healthcare treatment, and depicted patients incarcerated in establishments that could not meet their treatment needs.

- Different treatment by healthcare staff dependent on prisoner status

The ability to access treatment was a major concern. Life-sentenced prisoners were cited in the validation and male focus group as getting *preferential treatment*. One of them described his category as “carrying a certain status”. He was required to be escorted everywhere, getting access to meals and healthcare more quickly than others.

Older participants in the validation group and male discussion group expressed hostility towards the healthcare needs of younger prisoners. One validation group member commented that this group “barged their way through to the front of queues depriving older more needy patients of the care they require”.

The inequity manifest here is caused as a result of other prisoners’ own behaviour, it seems. It is not the inequity of healthcare services *per se* that is criticised, but prisoners’ widely different experience of accessing these within the complex prison community. These experiences could possibly support Pollock’s (2006) study which highlighted that the needs of the weak within the prison system were subservient to the strong.

- Failure to access healthcare prior to imprisonment

When asked why prisoners failed to access healthcare in the external community, one Head of Healthcare said it was primarily an issue of trust. She explained that, in her opinion, people raised in chaotic families often assimilate elements of illegal lifestyle, and learn early in life not to trust figures of authority, thus supporting the literature discussed previously (Easteal, 2001; Howerton *et al.*, 2007). This, she believed, was a barrier preventing these vulnerable young people obtaining the medical care and attention they needed, leading, in turn, to a life time of avoiding treatment and damage to their health. The underlying issues were both complex and multifactorial:

People don’t access healthcare outside because their lifestyle is too chaotic and something else always comes up. It’s a mafia type culture on the outside, fear of authority. They don’t have the money to get to the doctors, forget appointments, have poor literacy skills – don’t read or write... It’s easier to deal with the Asian women in prison because their husband isn’t sitting there: Acting Head of Healthcare.

- Lack of information about medical condition

The lack of information regarding their condition was also an issue for participants. One man said he had waited in pain for eight months after requesting an X-ray for an injured wrist. He finally had the procedure, but was still awaiting his results three months later.

- Treatment based on risk posed to prison

Paradoxically, this study also identified that, at times, being considered a disruptive influence had the opposite effect and led to preferential treatment. One validation group male participant spoke about young prisoners being demanding and aggressive with healthcare staff. Staff, he said, would then let them leap the queue to ensure wider trouble did not flare up within the prison. One male validation group member commented that “elderly prisoners’ health needs suffer because of young ones. Them that shout loudest get treated first!” This sub-issue shows how difficult it is to provide equitable treatment in an environment in which security considerations always take precedence.

5.1.23 Variation in Healthcare Provision

This theme presents the considerable variation in healthcare provision. It highlights the complex interface between internal treatment, external specialist clinical advice and the prison regime. This had a detrimental impact on prisoners’ health and wellbeing.

- Wait worsened condition

Examples of being denied medical treatment, sometimes for years, were also common. One woman, who had become disabled as a result of this, said that the hospital had told her “if I had been sent to hospital earlier it wouldn’t be so bad”. The same participant also said “it’s been marvellous here. I can’t fault them at all but it was terrible there”. She said that she lived in constant fear of being returned to closed prison conditions where she had previously had a nervous breakdown.

5.1.24 Waiting Times

Excessive waiting times for some procedures/treatments were also a source of complaint for participants. Participants in the validation group, however, reported that their experience was better than the waiting times their family and friends experienced “on the outside”, highlighting a wide variation in these participants’ experiences.

- Waiting time for chiropodist

Chiropodist waiting times were generally reported to be too lengthy and in need of reducing. One male correspondent commented I’ve been waiting 17 weeks to see the Chiropodist; you have to go on to a list.

- Waiting time for dentist

Long waiting times to see dentists, opticians and chiropodists were a frequent source of concern for participants. Lack of holiday cover for the regular dentist was reported by validation group participants, complaining that their teeth would fall out due to infection whilst waiting for the dentist to return. One group member opened his mouth to demonstrate how his teeth were decayed and hanging loosely from his gums. The inability of the healthcare department to provide urgent dental treatment for those in acute pain or need was also reported by both the male and female focus group. As mentioned earlier, it was frequent for participants to mention that they had considered legal action in an attempt to access treatment. The male focus group posited that this caused delay.

These findings support previous literature which highlights the prevalence of dental disease amongst prisoners (Cropsey *et al.*, 2006). They would suggest that the commitment to provide high quality dental care for prisoners, and to facilitate better access for those in urgent need (Harvey *et al.*, 2005, p. iii) is still far from completion.

- Waiting time for doctor

Waiting times to see prison doctors were also reported to vary considerably:

Depending obviously, if it was life threatening you would be seen straight away. I would say well yeah well it depends on the officers like. That lad he waited all night in pretty much in excruciating pain: young person interviewee.

- Waiting time optician

The male validation group participant below said that in his current prison waiting times for specialists had reduced. He commented that in previous prisons waiting times were about one year to see an optician.

5.2 Conclusion

This chapter has presented and debated the broad range of participant experience arising from this study. It has been discussed often via the words of participants themselves, ensuring that the meaning of their narrative and what people actually said verbatim is included, thus remaining faithful to the methodological framework applied.

It is hoped that by presenting this material, this under-researched community would be given an authentic voice via research, and true to the Case Study method, readers of this study would be able to “smell the very breath of participants”, (Thomas, 2011, p. 7). Further, it may be possible for people to better understand the complexity of participants’ daily existences behind the prison walls. Moreover, a greater awareness of the challenges posed to those commissioning and providing healthcare services may also be appreciated.

The three Key Themes identified are:

	Key Themes
Healthcare Setting	✓
Patients’ Behaviours, Health and Outcomes	
Service Commissioning and Delivery	

'Patient Experience of Equivalence'

Participant narratives would suggest that the provision of NHS patient services within the penal setting is problematic. Participants' contributions highlight the incompatibility of patient care and treatment situated in a prison system designed to restrict movement and prevent escape. This thesis would suggest that this tension is central to many of the inequities highlighted in the preceding dialogue.

	Key Themes
Healthcare Setting	
Patients' Behaviours, Health and Outcomes	✓
Service Commissioning and Delivery	

'Patient Experience of Equivalence'

Participants' spoke about a complex range of adaptive behaviours, many of which were damaging to their health and wellbeing. As a patient population *per se*, participants are unable to exercise true *patient choice* granted to their counterparts in the general community. In this sense, their experience is inequitable.

Within this Key Theme, the inequity is further complicated by prisoners living within a hierarchical prisoner culture and prison regime. Healthcare equity must, therefore, be considered not just in relation to the general community, but also within the prison community itself between various patient cohorts.

	Key Themes
Healthcare Setting	
Patients' Behaviours, Health and Outcomes	
Service Commissioning and Delivery	✓

This thesis would suggest that imprisoned patients' access to NHS care and treatment is highly complex. Numerous tangible and intangible barriers arise between the penal environment and Care Sector preventing a smooth interface. These difficulties exist not only between the prison and external NHS providers, but also between internal patient services, as exemplified by the issues related to pharmacy opening times previously highlighted.

This study will conclude with a discussion of these problems presented under the three Key Themes previously identified:

1. Healthcare Setting,
2. Patients' Behaviours, Health and Outcomes,
3. Service Commissioning and Delivery.

CHAPTER SIX: DISCUSSION OF FINDINGS

People [’s health] is influenced by their upbringing, by their peers, by their financial status, by whims, by ambition, by culture, by society, by law, by random events which occur... When a psychologist undertakes to discover why someone does something, they take on the world in all its complexity

Forshaw (2002, p. 2).

6.1 Introduction

In this concluding chapter, Core Theory is constructed from the healthcare policy promise of equity and the quantum of knowledge pertaining to prisoner health in the literature. This also combines items from coded data about the healthcare experience of imprisoned patients and their ability to access prison healthcare, equitable or otherwise, in the prison environment.

From the data, it appears that, despite considerable policy focus and activity, the lack of integrated health and social care service commissioning means that equitable provision has not been experienced consistently by imprisoned patients. In its absence, prisoners (in this study) have themselves adopted the role of carer for the sick and frail amongst their wing-based community/ies. Participants report that they undertake these caring roles unsupported by the NHS and/or the Prison System. They do so at considerable risk to both themselves, and the person for whom they care. This represents a novel finding of this work.

In a PhD thesis it is important to highlight overtly the work’s original contribution to knowledge. The preceding literature review sections detail the knowledge gaps in the field of prisoner health via the Equitable Healthcare theoretical framework and Public Health Agenda. Need for this research was demonstrated. It is now crucial to show the results of this case study which develop the body of knowledge in a novel and worthy sense.

All analytical discussions of the data represent innovative debates. It is useful, however, to state just four main findings here that represent important and unique contributions to this field of academic endeavour:

1. The custodial setting in both cultural and physical respects affects the healthcare and health of prisoners. This specifically impedes the priorities of equitable healthcare in this institutional environment. Examples are included in Key Themes Service Commissioning, Delivery and Constraints presented in Figure 21 to follow.

2. Integrated healthcare services re: mental health and substance misuse is arguably necessitated to more appropriately approach and manage imprisoned patients with connecting health issues. Examples are again included in the Patients' Health and Patient Outcomes Key Theme to follow (Figure 21).

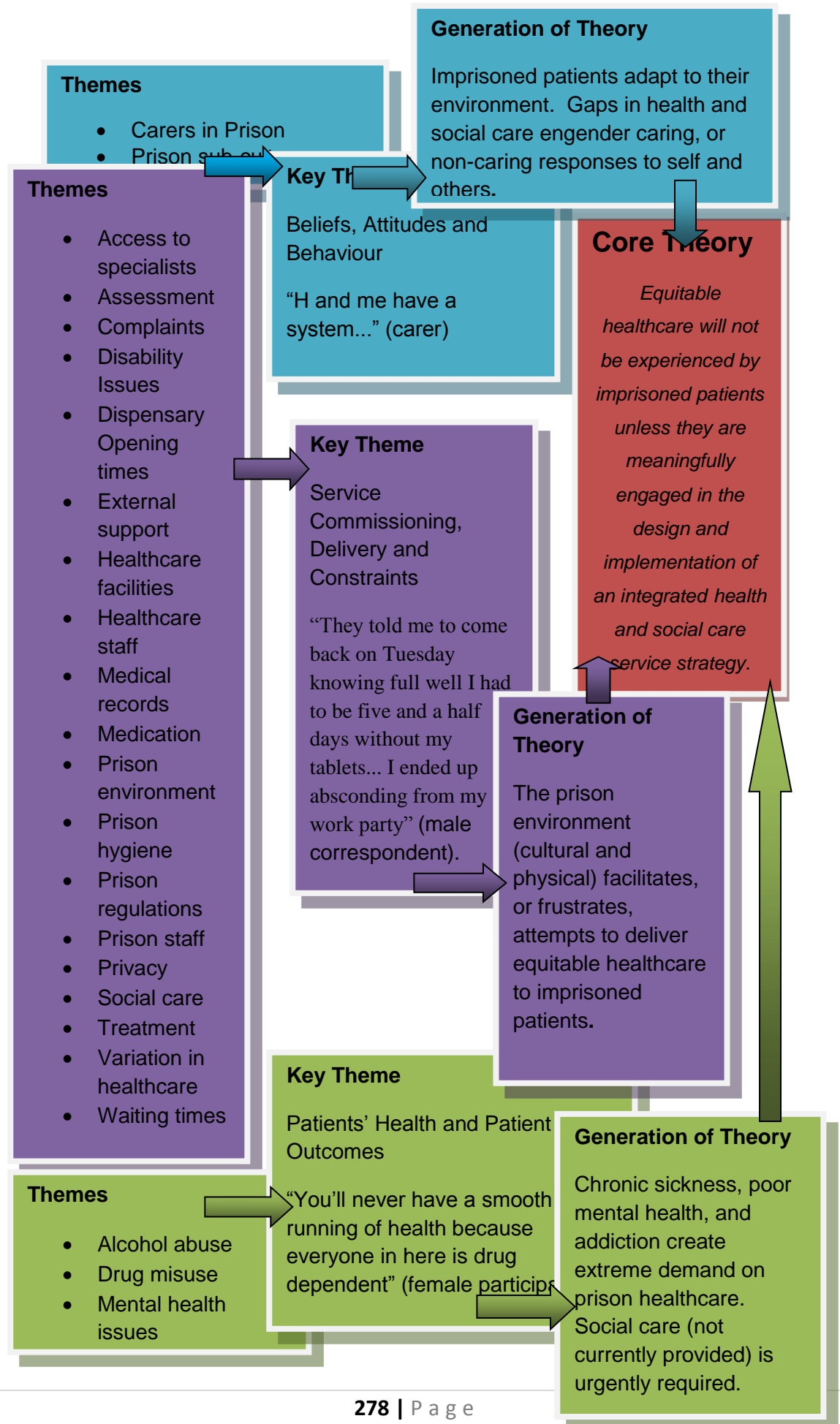
3. Social care services are arguably required through HM Prison Service. Examples appear within the Key Theme Beliefs, Attitudes and Behaviour to follow (Figure 21).

4. Prisoners are undertaking caring roles amongst themselves on the prison wings devoid of assistance from the Prison Service and NHS

The Core Theory arising from this study, and examples described above, is presented in Figure 21 to follow.

Figure 21

Generation of Core Theory



Commentary is structured according to the three Key Themes presented in Chapter Four:

- Healthcare Setting,
- Patients' Behaviours, Health and Outcomes,
- Service Commissioning and Delivery.

It is worth noting that this study set out to understand the lived experience of participants. Despite considerable access barriers, the research data collected via the fieldwork is first-hand and, exemplifies prisoners' healthcare experiences within the penal setting. The authentic voice of imprisoned patients, which first emerged from the data in Chapter Five, is used selectively to illustrate key points in this chapter's discussions. Thus, it remains faithful to the commitment made to participants, and the methodological approach adopted.

In addition to the three Key Themes presented, the research data will be synthesised as a whole body of knowledge, and is debated under the Overarching Theme *Patient Equivalence*. Those conditions considered fundamental to Case Study research will be answered here, taking this study beyond the simple description of participants' accounts. These questions are (Thomas, 2011):

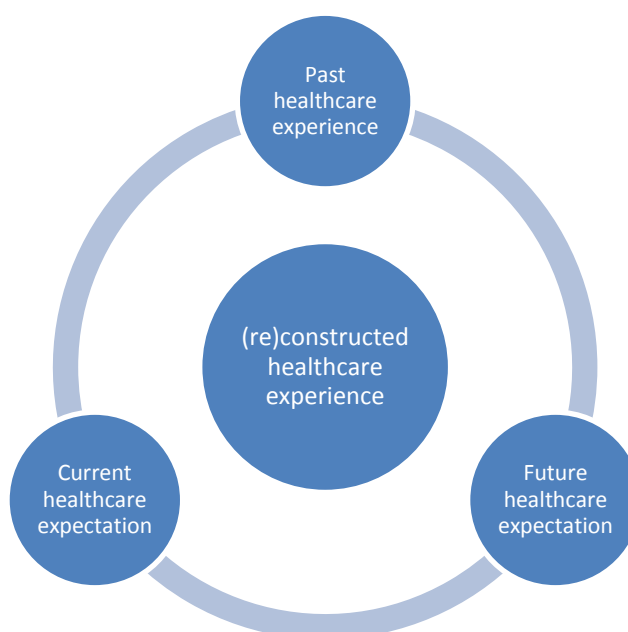
1. What happened here?
2. Why did it happen?
3. How did it happen?
4. What was connected to what?
5. What was the impact on imprisoned patients?
6. What was the inter relationship between the various factors involved?

The study's first question revisited:

Regarding the first study question, namely *In what ways has the policy promise to deliver equitable healthcare been (re)constructed and experienced by imprisoned patients?*, numerous participant accounts have been offered and discussed in this thesis. Those pertaining to behaviour and its impact on their healthcare experience will now be considered.

Imprisoned patients exist in a complex web of human interaction, within which they construct their healthcare experience. Here, it was found that their present *reality* had also been greatly influenced by their health and healthcare experience in the past. What they expect to receive now, and in the future, are also important influences to health. Some aspects of these constructs were common amongst their peers, whilst others remained unique and deeply personal.

Figure 22 Prisoners' (Re)constructed Healthcare Experience



It is important to also reflect that participants underwent a process of primary socialisation, long before they were imprisoned. For many, this took place in a socially disadvantaged or abusive environment (Braveman and Gruskin,

2003; Easteal, 2001; Howerton *et al.*, 2007). As a result, despite the chronic level of sickness prevalent amongst this group, services are frequently feared or shunned. Confirmation of this phenomenon came from the Head of Healthcare interviewee who commented:

Fear of doctors is very much a family culture, fear of what they're going to be told they've got, they often sleep in the day if they're night workers [prostitutes], fear of loss of children, person coming might be nosey...

Thus, from an early age, the *past healthcare experience* element of their constructed view is likely to be poor.

This assertion finds support via the extensive literature pertaining to the process of primary socialisation. Social Construction Theory corresponds well with this thesis, asserting that primary socialisation takes place in emotionally charged environments, and is much more than purely cognitive learning (Berger and Luckmann, 1991). This work aptly acknowledges that imprisoned patients' healthcare experiences and beliefs are significantly influenced by these factors.

Those participants, who had been poor users of NHS facilities pre-incarceration, were not in a position to compare their prison healthcare experience to that of the general community. Its equitability could not, as a result, be assessed. This study did not find a way to overcome this. Indeed, many participants accessed healthcare services for the first time in prison. This was expressed by the young person interviewee who, when asked why he had failed to get a testicular lump examined, replied: "I had other things on my mind out there". On reflection, however, this was not considered detrimental to this study, as it was concerned primarily with prisoners' experience of NHS provision in the penal setting. Prior healthcare comparison was, therefore, a sub-set of data for some, and not fundamental to the eventual research constructs.

Participants' expectations of the quality and equitability of prison healthcare varied considerably. For some, there was a clear understanding of their legal rights to equivalence, both in relation to healthcare services and other prison

provision. Conversely, other participants expressed surprise when informed about their right to services *broadly equivalent* to those offered to the general community.

Equitable provision to prisoners is further complicated as it is delivered to patients who also undergo a process of secondary socialisation into prison (Glaser, 1967). Also, they are both patient and prisoner. It is posited here that, as a result, their healthcare experience differs significantly to external patients.

Academics and criminologists suggest that prisoner secondary socialisation is complex (Glaser, 1967; Hensley et al., 2003; Huggins et al, 2006; Morello, 1961; Rivera et al., 2003; Wolff and Shi, 2009). This found support in participants' narrative, and opinions gathered during the fieldwork phase of this research. Numerous participant accounts describing the powerful impact that prison culture (including an unofficial prison culture/regime) has on their mental wellbeing and behaviours are relevant here. Not being seen as disruptive, or "rocking the order of things", was said by the young person interviewee to determine whether prisoners reached open conditions, or a more favourable regime. The quality of participants' interaction with prison staff, for some, could ultimately secure their release. One female focus group member said that this meant having to comply, or cooperate, with things that would earn them *points [Incentives and Earned Privileges]*, even if they fundamentally disagreed with the principle of these.

Recognition of difficulties with sentencing policy is increasingly published (HM Chief Inspectorate of Prisons, 2009; Johnson and McGunigall-Smith, 2008; Prison Reform Trust, 2007, 2008b). The current system, one participant argued, has created a situation in which it is now "impossible to earn sufficient credit for release". Thus, this thesis supports contemporary literature highlighting the necessity to review sentencing policy and processes for course completion in prison to achieve release.

Participants frequently narrated their lived-experience within a social hierarchy in their own *Argot* (language) as previously presented. One's place within this greatly influenced their experience of prison healthcare. Here, it was found

that healthcare inequity was widespread between prisoner sub-populations. Physically strong *lifers*, for example, experienced swift and effective care. Other prisoners acknowledged their higher *status* and right to services. Those lower in the hierarchy, such as the frail or mentally ill, were offered services which they considered to be poor, as highlighted by a male focus group participant: “they [*pointing at a life sentenced prisoner sitting beside him*] always get the best. We get whatever’s left over”. The *lifer* readily concurred with this view.

There are strong arguments in favour of challenging some of the inappropriate and health-damaging aspects of the prisoner social hierarchy. Bullying, a problem previously reported (Ireland *et al.*, 2009; Wolff and Shi, 2009) is considered by academics to be particularly problematic. This research would support this assertion.

An economic-oriented concern, narrated by one elderly male participant highlighted another health-damaging aspect of prisoner behaviour: “some of the sick older prisoners here are so desperate for money they sell their medication to buy basic necessities”. The chronic level of poverty amongst the elderly worried a number of older participants. This supports previous findings (Smith *et al.*, 2007).

Healthcare was extremely important to participants. At times, this engendered extreme hostility towards prison healthcare staff. The prison regime also attracted criticism. Participants were quick to make disparaging remarks about each other also, if they felt individuals were feigning illness or disability, diverting scarce health resources from where they were most needed.

At times, despite a clear risk to their own health, the powerful hidden rules of prison life prevented participants from approaching healthcare staff to access the health, and other, services. The statement “we don’t tell them anything Miss” was often heard and narrated previously. The health psychology model *The Theory of Planned Behaviour*, built on the *Theory of Reasoned Action* (Ajzen and Fishbein 1970, 1980) offers a useful framework to consider these perverse actions. This theory introduced the notion of perceived behavioural control. How much a person believes they have control over a health-related

behaviour, and whether the *subjective norm* of their peers would support positive change are important factors if individuals are going to take remedial action.

Here, the *subjective norm* of imprisoned patients' represents a powerful counter-force to individual and collective health-improvement. Whether the *patient code of conduct* observed relates specifically to prisoner health, or is a sub-set of the previously documented *Jail Law* (prisoner code) (Rosen, 1990), was not determined. This may be another area of useful academic endeavour.

Prisoners narrated gaps in health and social care services for their vulnerable peers. Into this resultant care vacuum, other prisoners chose to step accepting the role of *carer*.

Imprisoned carers have not been previously identified despite an earlier extensive review of the carers' literature (Pollock, 1994). Carers *per se* are recognised legislatively. Here, the *Carers (Recognition and Services) Act 1995* (p.2) defines carers as "those giving substantial amounts of care".

This raises an interesting legislative question: are imprisoned carers also entitled to a carer's assessment and provision of services to support them in their caring role? Further, under the terms of the *Carers and Disabled Children Act 2000*, carers are entitled to a carers' assessment if they are aged 16 or over, and:

"provides or intends to provide a substantial amount of care on a regular basis for another individual aged 18 or over ("the person cared for"); and

- a) asks a local authority to carry out an assessment of his ability to provide and to continue to provide care for the person cared for

The local authority must [original emphasis] carry out such an assessment if it is satisfied that the person cared for is someone for whom it may provide or arrange for the provision of community care services. For the purposes of such an assessment, the local authority may take into account, so far as it considers it to be material, an assessment under section 1(1) of the [1995 c. 12.] The Carers (Recognition and Services) Act 1995 Subsection (1) does not apply if the individual provides or will provide the care in question:

- a) by virtue of a contract of employment or other contract with any person;
or
- b) as a volunteer for a voluntary organisation”.

As imprisoned carers are not under contract to provide their support and are not volunteers in a voluntary organisation, it would seem that they fulfil the criteria for subsection (1) above. Indeed, imprisoned carers are more likely to meet the requirement to provide a substantial amount of care on a regular basis also. They may, therefore, be entitled to request a carers’ assessment of their own needs, and those of the person for whom they care, from the local authority.

Similarly to the literature, imprisoned carers are neither mentioned in any of the carer legislation or the Government Strategy on Carers (2008) *HM Government ‘Carers at the heart of 21st- century families and communities: A caring system on your side. A life of your own.* It is likely that this carer community was not previously imagined. It is further possible that the chronic needs of the imprisoned care for are also unrecognised by the wider community. Prisons are not discussed often in the political media or discourse and, when they are, it is often the negative ramifications of offending that receive attention.

It is likely that there are a large number of unrecognised informal carers in prison in England. The research data continued to identify further examples of prisoners who had taken on this role and responsibility in the penal setting. Why they did so differed considerably. Some said that their current prison regime appeared to be hostile, or uncaring towards those prisoners in need of assistance.

Others described taking on this responsibility because social care was absent. Conversely, this was not the experience of everyone. Female focus group members reported that, in their current prison, they received sufficient support from staff. As a result, they said they had chosen not to become carers, although they had frequently done so in previous establishments.

Thus, the existence of informal carers across the prison service is not uniform, and depends significantly on the regime, and services in individual prisons.

Female participants also said that *caring* was openly acknowledged and accepted amongst their peers. Family groups were also recognised. This assertion supports Giallombardo's (1996) finding that women prisoners form pseudo families due to close emotional links. It possibly also supports Pollock's (2006) belief that these groups form due to the wider role women assume in society. The practice appears, however, to contradict Lauderdale and Burman's contention that these female groupings are largely unrecognised by prison staff. Indeed, one prison Governor in this study spoke at length about womens' groups forming along racial lines. She disclosed the "vicious punishment metered out by the Aunties", suggesting that pseudo families perform a discipline-enforcement function going beyond the role theorised by Giallombardo (1996) and Pollock (2006). Here, this was identified to be more akin to the behavioural attributes of male gangs, widely reported previously in the literature (Morello, 1961; O'Donnell and Edgar, 1999; Rivera *et al.*, 2003; Rosen, 1990), thus suggesting that the pseudo family label attached to women prisoners should be revisited.

Caring for each other, one female said, was a part of "a woman's nature". They argued that, in contrast, male prisoners would not offer this form of informal social care [*professed when viewing the pictorial representation of this activity on the graphic board*]. The data for this study demonstrates this is not the case. Female prisoners' assumptions regarding their male counterparts did not match the male participants own views. The young (male) participant interviewee also spoke about the way his peers cared for each other in the prison setting. Here, he said, this resulted from pre-imprisonment friendship and was, as such, neighbourhood-related.

Despite its widespread nature, the activities of imprisoned male carers were not widely accepted or supported in male prisons. One male carer professed his fear of being placed on a charge if his activities were discovered.

Although this specific concern is previously unrecognised in the literature, it could relate in part to previous findings suggesting that prisoners are pre-

disposed to protect those who they believe to be deserving of their help (O'Donnell and Edgar, 1999). Contrary to this study's findings showing that prisoners felt that sex offenders *deserved* to be attacked, some of the cared for were known to be sex offenders. This suggests that O'Donnell and Edgar's (1999) findings may also require revisiting.

Many of the cared for identified here would be recognised as *vulnerable adults* (Great Britain, 1995), within the legislation. Imprisoned carers themselves also recognised the vulnerability of the people they cared for. Without urgent risk assessment on a case-by-case basis, the risk highlighted here will persist. It is also posited that carers themselves require protection. Formal recognition and support, in tandem with research and development, could identify the information and provision required. This could not only assist imprisoned carers in their tasks, but also protect their health and wellbeing from harm.

Vulnerability amongst the prison population comes in many forms and a significant body of penal literature is currently focused on the addicted. Examples were found to support a perception of the widespread nature of this (Fazel *et al.*, 2005; Griffin, 2007; Joseph, 2006; Roberts *et al.*, 2007; Stewart, 2009; Webster *et al.*, 2005). Female Focus group participants in particular described the prison system as being in a state of crisis. They frequently complained that prisons were increasingly full of young addicts who did not belong behind bars within a system doing nothing to help them.

Substance abuse and addiction within HM Prison Service is a contemporary concern. Prison, these participants felt, would serve no useful purpose regarding their rehabilitation. Taxpayers' money, they argued, could be better spent trying to get individuals detoxified. These views had been previously voiced in discussions with imprisoned women, indicating the widespread nature of this concern.

Regardless of whether one views addiction as a response to stress (Hussein Rassool, 2006; Hussein Rassool, 2009), or genetic predisposition (Jellinek, 1960; Valliant, 1983) discussed previously in Chapter Two, the damage to an individual's health is unquestionable. Here it is posited that, without sensitive, effective and lasting treatment, the healthcare status of this group will not

improve. There is a danger that we are witnessing a generation lost. Understanding the underlying behaviours within this population is crucial to successful intervention.

To conclude this section, prisoners' experience of equitable healthcare is (re)constructed and experienced differently, depending on a number of fundamental factors, such as previous life experience and one's status within prison society. These factors both individually, and collectively, appear to have created a powerful *subjective health-related norm*, affecting imprisoned patients' access and experience of healthcare provision.

Prisoners' experience of healthcare is also affected by the setting in which it is delivered. The relationship of this Key Theme to the first research question now follows.

6.3 Healthcare Setting

This research experienced the healthcare setting unique to English prisons. Those granted access to this environment report being profoundly affected by their experience. One study vividly described this:

[...] the experience of returning into our own world was disturbing; we experienced a sense of detachment and disorientation, and a frustration at wanting to share the experiences with others, and yet finding a way of describing what we had experienced almost impossible (Liebling, 1999, p. 161).

Here too, the researcher was similarly affected. The plight of men and women, in particular, who had been harmed by prior life experience and imprisonment, at times overwhelmed. The desperate pleas of older men subject to ongoing bullying, women living in constant and acute pain brought on by medical negligence, and a terrified man who was convinced that a ghost shadowed him, remain painful memories. Some prisons did little to help. Others cared deeply and did everything they could to assist, in each case reflecting the professional approach of the Governor.

In these cases, spontaneous acts of human kindness and a depth of compassion for the vulnerable was witnessed. Amongst the imprisoned, compassion was manifest through the strong emotional bonds formed between individuals. This was found also amongst prisoners and prison healthcare staff. One female prison Governor spoke of a woman in her “care”. This woman’s life, she said, had been “horrific”, the worst case she had ever seen in her long career. Unable to cope with closed prison conditions, this woman had come to her in a state of complete collapse. She would never “be able to function outside”, but “it’s alright”, she continued, as “she’s never going to leave this place”.

Against this background, participants shared their healthcare experience despite a fear of personal retribution. These matters will be returned to in the Limitations section of this thesis. This willingness, bravery and generosity enabled a wealth of research data to be gathered about a population frequently hidden from research (Liebling, 1999).

Prison healthcare is delivered, therefore, in a setting beset by challenges. First is the dramatic rise, over the past two decades, of the prison population. This has resulted in severe overcrowding which was a common concern for the 74 prisons represented in this study (Ministry of Justice, 2009). Staff and prisoners alike described the severe pressure that this had placed on healthcare facilities. Yet, this thesis would assert, from its inception, equitable healthcare policy has been founded on the belief that *fair* delivery can exist despite these conditions.

This was not necessarily the case. One male participant, for example, complained bitterly that overcrowding had created a specific disadvantage for elderly patients who, as a result, had to queue outside in the rain for healthcare services. Younger fitter prisoners, he said, would injure the sick and vulnerable pushing them aside to access services. Another man commented that insufficient healthcare facilities had also created an internal “pecking order”. The weak, elderly, learning disabled and mentally ill, now found their needs placed behind those of the strong. This, he argued, was the only way the prison could prevent unrest, an issue widely supported in the literature (Ireland *et al.*, 2009; Wolff and Shi, 2009).

The anxiety here is twofold. Firstly, the impact of increased numbers without commensurate investment to expand healthcare creates situations like those described above, supporting earlier findings in the literature (Bradley, 2009; Docherty, 2009; Home Office, 2007; NACRO 2004a, 2007; Ramsbotham, 1996). Secondly, these findings would substantiate the anxiety expressed when the prison operating margin was lost (Ministry of Justice, 2009), discussed previously in Chapter One. Thereby, creating a volatile environment in which prison staff can no longer place physical space between prisoners who would be dangerous if housed together. This, it has been argued, has exposed the vulnerable to physical and emotional harm despite the efforts of those campaigning for safer conditions (Prison Reform Trust, 2009a). No answers were identified to these pressing issues.

In one discussion, a prison officer described it as the prison system “running hot”. She added that there had been “more prisoners on the nets in the last eight months than in the previous eight years that I’ve been in this place” *[on the nets describes prisoners throwing themselves off the landings onto the safety nets below as a form of protest]*. This issue was not found in the prison research literature to date. This is possibly another original finding of this study highlighting the need for additional work in this area.

The healthcare setting was found to be particularly problematic for the increasing population of the incarcerated elderly, frail, mentally ill, long-term sick, disadvantaged, addicted and dying. These groups pose a significant challenge to a setting which is ill-designed to respond (Bradley, 2009; Braveman and Gruskin, 2003; Condon *et al.*, 2008; Fazel *et al.*, 2005; Hayward *et al.*, 2008; HM Inspectorate of Prisons Youth Justice Board, 2009; Moran and Peterman, 1989; Stewart, 2009). Notably, despite increasing empirical data highlighting this issue, strategic investment in appropriate healthcare facilities at a population-wide level could not be located.

It is posited here that the increasing numbers of geriatric prisoners, or those with long-term / palliative care needs, requires a more radical solution. Visiting the cells of participants confirmed one Governor’s earlier remark that the available space could not accommodate the equipment required to care for the elderly, sick or dying. On one such visit, discussed in the previous chapter, a

prison officer said that one of the room's residents had to wash his colostomy bag out in the shared sink as there was nowhere else. He commented that it was not uncommon for others to do this in the communal showers. De Viggiani's (2007) assertion that prison environments are unhealthy finds considerable support here.

Academic argument that prison is not the appropriate place for many housed there is also well established (Badr-El-Din; 1978; Bradley, 2009; Davies, 1976; Home Office, 2007). In 2009, HMCIP argued that the reason why there had been an increase in the number of sick and vulnerable people being placed inappropriately in prison was the scarcity of secure accommodation elsewhere. This study confirms this. In particular, it found that the prison healthcare setting is also being used to inappropriately accommodate people who have acute community or social care needs. Care in the Community is increasingly becoming Care in the Prison Community, it would seem.

This thesis would suggest that the absence of social care in HM Prison Service represents a current problem that requires both attention and development. Moreover, the ageing prison population shall serve to amplify this issue for the service if not addressed swiftly.

Yet, no mention was made of the prison community on the 14th July 2009 when the Government published its long-awaited Adult Social Care Green Paper, despite the fact that many of the participants in this study would meet this document's announced *single eligibility threshold* for service provision. This suggests that prisons are not yet fully embedded in mainstream government policy and thinking, further impacting the provision of equitable healthcare services.

Many individuals also meet the definition of *chronically sick and disabled* under the terms of the *Chronically Sick and Disabled Persons' Act* (Great Britain, 1970), as well as that of *vulnerable adults and young people* within *The Disability Discrimination Act* (Great Britain, 1995). These key Acts lay the legislative framework which makes it unlawful to discriminate against disabled persons. PSO 2855 further placed responsibilities on prisons in relation to disabled prisoners in 2003. An overarching theme was that prison

governors must ensure that *reasonable* adjustments are made to meet the needs of disabled prisoners and enable them to participate in prison life wherever possible.

In the same way that NSFs had previously outlined what could be expected from services, underpinning *The Disability Discrimination Act* (1995) were very specific measures to prevent discrimination. In particular, disabled people were required to have equal access to opportunities, facilities and services, and should not receive a lower standard of treatment or service quality as a result of their condition. Prisoners with sensory or mental impairment which has an effect on their ability to carry out normal day-to-day activity also receive protection. This left little room for confusion. Yet, the experience of disabled prisoners continues to be poor (Bradley, 2009; Loucks, 2007; Yorston, 2004). One participant amputee featured earlier in this thesis applauded the prison for finally supplying her with a wheelchair, but added that her cell was on the third floor landing which had no disabled-lift or toilet facilities. Whilst some positive steps have been taken, more remains to be done.

For those charged with legislative compliance (in the face of powerful anti-discriminatory legislation) creating an appropriate therapeutic environment in a prison setting remains a challenge. One Head of Healthcare commented: “it’s a bit like a nursing home in some places. I didn’t realise how much caring was going on inside...”

Reactive practice of this nature has been previously recognised. For instance, HMCIP (2009, p. 42) published, in its surveys that one in six prisoners identified themselves as having a disability and highlighted an “endemic lack of facilities”. Endorsing HMCIP’s findings, this study would further suggest that the poor physical nature of the prison estate, and an absence of any mechanism to transfer the chronically sick or disabled to one of a limited number of appropriate healthcare settings, have placed many prisons in considerable risk of breaching PSO 2855.

This remains the case despite many prisoners becoming better informed about their legislative rights. Eight participant correspondents and one female focus

group member had successfully challenged and overturned poor health-related decisions. The litigation they cited was, without exception, targeted and specific, demonstrating significant legal knowledge. It was unclear how these participants had acquired this awareness.

Healthcare Departments in prison are situated within the context of the wider prison regime. This is uniquely challenging. Moreover, in all matters, the governing governor has the power to decide what s/he feels is best for her/his establishment. Security overrides clinical practice and NHS services, and custody-related judgements were found to be swift and without explanation. In one case, a member of healthcare staff had been personally escorted off the premises by the Governor. This had been sudden and without notice. Several weeks later she remained excluded, and her frustrated manager could not obtain an explanation for this.

It is possible that the Governor's actions were entirely justified. However, the lack of transparency and engagement between those charged with equitable healthcare delivery contradicts the policy emphasis described in section 1.9.3. Here, effective partnership was described as an essential ingredient of service reconfiguration and improvement (Department of Health, 2008c). At an operational level, the needs of those charged with compliance and obedience are witnessed to come into direct conflict with those charged to deliver equitable services within the healthcare setting. Further, the prison regime conflicted with the care and treatment of patients. This is of relevance to the care-versus-custody debate.

Prison-specific policy and security were cited as the reasons for this. Prison rules, in particular, were found to create physical barriers to healthcare, and acquiring prescribed medication came into frequent conflict with work duty. Participants, sometimes in acute pain or with mental health conditions, were reportedly prevented from taking their medication for several days. Generally, this was because they had returned from work duty at the allotted time only to find the dispensary closed. One young offender wrote to say that he had been so distressed by this, that he had attempted to commit suicide. This raises the issue of inappropriate institutional response. Clearly, these individuals experience healthcare as prisoners first, and patients last.

The *Social Cognitive Approach* to health psychology emphasises that people process information in the social context within which it is presented (Rodham, 2010, p. 32). Through the complex interaction between the prison setting and the cognitive processes outlined in the previous section, participants constructed their experience of prison healthcare provision. This perception, for the majority, was reported to be poor and was not seen as equitable. For imprisoned carers, their constructed awareness of inadequate prison health and social care led to them taking on this role.

Moreover, there were distinct gaps in a number of healthcare services that were commonly offered to the external community, leading to a difficult and expensive requirement to escort prisoners to external treatment. Participants argued that treatment in prison, (only going out to external appointments when it is absolutely necessary e.g. use of MRI) would reduce security risks and costly escort requirements. It would also reduce prisoners' humiliation (particularly the handcuffed), when taking them out for treatment. The acute embarrassment of women in such circumstances has been previously identified by Wahidin (2004). A reduction in the risk of escape was also acknowledged.

Both participants and staff argued that some routine treatment, such as suturing [applying stitches to wounds], would make sense to be provided in the prison itself. This study found, however, that the inadequate level of hygiene in many prisons currently presents a barrier, as narrated by prisoners. Nonetheless, the potential cost benefit of these suggestions warrants serious consideration.

Requiring specialist treatment outside the area in which the person is imprisoned was also found to create difficulties, clearly confirming healthcare inequality when compared to the experience of the external community. At present, there are no mechanisms to transfer individuals onto a hospital consultant's waiting lists in other NHS Trusts. Here, it is suggested that patient's health could suffer as a result, since the standard of care and treatment a prisoner receives is, at times, dictated by their current prison establishment. Prison conditions, policy and practice were, therefore, found to

create real barriers to facilities. These matters demand serious academic attention.

To conclude this section, imprisoned patients co-exist with their reality as prisoners in the prison healthcare setting which has been primarily designed to enforce rules and prevent escape. This was often seen to be incompatible with their needs as patients.

The objective reality of prison as an institution predominantly designed to *control* collided, with at the point of transfer to NHS responsibility, another institution embracing a very different matter of etiquette. It is within this context that the third Key Theme identified in this study is used to consider the second research question:

Considering the findings from this research, can NHS policy be effectively formulated and practiced for this chronically sick and disadvantaged incarcerated patient population, and, then, can equitable healthcare be coherently and consistently constructed within NHS policy in tandem with its construction by the patient prisoner population?

6.4 Service Commissioning and Delivery

Berger and Luckmann (1991) assert that the meeting of a new institution with equal standing to one's own can be problematic, as it can challenge both the order, and taken-for-granted assumptions.

Therefore, when on the 29th March 1999, the NHS and Prison Service jointly announced a partnership to reform healthcare for prisoners, two institutions with an entirely different history and purpose came together. The policy framework was clear, and prisoners should now to receive “the same quality and range of health care services as the general public receives from the National Health Service” (Joint Prison Service and National Health Service Executive Working Group, 1999, p. 5).

This study has discovered that this assumption may have been unrealistic. Equivalent care is not experienced consistently by the participants in this study. Instead, their individual and collective experience was found to be an intricate construct. This, suggests that it may be useful to consider, and define, what *equivalent care* means in a secure environment. It is important to reflect that patients in the external community also experience wide variation in healthcare provision. Here too, as the Inverse Care Law demonstrates, inequity exists (Tudor Hart, 1971). Equity is certainly a convoluted healthcare endeavour.

As the key mechanism through which health inequalities should be reduced, World Class Commissioning (Department of Health, 2007, p. 7) required that commissioners take a strategic and long-term approach to the delivery of “fair” provision. Fundamentally, this required a long-term view of investment to tackle inequality.

At the same time, section 116 of the *Local Government and Involvement in Health Act* (Great Britain, 2007) introduced a duty for local authorities and PCTs to undertake a JSNA of the health and social care needs of the area. The importance of this assessment for prisoner health cannot be underestimated, as it is the process whereby the health and wellbeing needs of this population should inform commissioning priorities, in order to improve patient outcomes and reduce inequalities.

Healthcare in prisons required effective integration into plans for local services, if the effective delivery of JSNAs was to be achieved. Despite this policy commitment and focus, in its 2008/09 thematic reviews, the Healthcare Commission (2009, p. 11) found:

Thirteen out of eighteen PCTs told us that prisons were not included in local area agreements and, in a number of cases, there was either no strategy for commissioning healthcare in prison or the strategy needed updating... Assessment of needs for healthcare does not seem to have improved since 2006/07.

Notably, healthcare assessment of needs had not improved over a three-year period. Arising from this, it was recommended that PCT boards should regularly assess compliance with this responsibility before signing off the

process. The Healthcare Commission (2009) also argued that PCTs should adopt a more structured approach to resources.

Despite improvements in electronic information management, the Commission found confirmation that co-ordinated care was in fact deteriorating. Service plans were found to look good only at a surface level, although these did enshrine the principle of equivalent care. No examples were found of improved outcomes for patients. More optimistically, The Commission also found that PCTs felt that they had good and effective relationships with the prisons in their area. This, however, contradicted HMCIP's finding of a lack of cohesive working between the teams delivering primary and acute care, "and sometimes between healthcare as a whole and the rest of the prison" (2009a, p. 29).

The extreme difficulty of prisoners trying to access acute care was frequently expressed by participants. Their experiences support HMCIP's assertions, and include cancelled operations, removal of prescribed medication upon return to prison, no knowledge of x-ray or test results and failure to take urgent cases to hospital (as in the case of the young offender who was left in his cell all night with acute appendicitis).

Many of these issues, both between agencies and within the prison itself arose, it is suggested here, because of a lack of an integrated treatment and commission plan for this patient group. Others happened because a regime of care was often found to misfit with the demands of a secure environment. The agony described by post-operative participants who were allowed "only paracetamol" should not be tolerated in a humane society.

This research discovered that PCT staff did not have a positive experience either, despite the national emphasis on partnership in section 1.9.3. One Head of Healthcare, featured previously, commented: "We're near the bottom of the shoe as far as the prison staff is concerned. They stand around and read papers while we get attacked".

Concluding this sub-section, the issues discussed here raise profound questions about whether the institutional culture of HM Prison Service and

the NHS are fundamentally incompatible. It must further be questioned whether a prison regime, principally designed to control, can incorporate effectively an NHS institution with a primary objective to provide equitable healthcare to patients?

In answering, this research would acknowledge the positive health-related action taken by some PCT and prison staff (particularly some healthcare governors). Despite the attendant difficulties, these individuals and prison staff are producing modern NHS treatment and facilities for imprisoned patients regardless of numerous obstacles.

However, returning to the second research question, in no sense could this be considered to represent equitable healthcare which is coherently and consistently constructed within an NHS policy framework. These issues will be returned to in the final section of this thesis.

6.5 The Case

Having discussed the three Key Themes identified, this study now considers those questions seen as fundamental to the Case (Thomas, 2011). These are presented in the following table:

Table 40

Case Study questions and their application to this study

The following table shows the list of Case Study questions pertinent to this study.

Question	Where located in thesis	Issue
What happened here?	Introduction Policy Narrative	Promise of equitable healthcare provision for prisoners Effective lobby, legislation demanded equity,

		NHS policy patient-centred for providers
Why did it happen?	Chapter One Policy Narrative	Lord Ramsbotham and Public Health Agenda in England Transferred responsibility for prisoner health care to NHS responsibility
How did it happen?	Chapter One	Policy and legislative framework
What was connected to what?	Chapters One, Two, Five and Six Literature Review, Findings and Discussion	24 themes Three Key Themes One overarching theme <i>Patient Equivalence</i>
What was the impact on imprisoned patients?	Chapters Five and Six	A continuation of variable care and treatment. Gaps in services leading to prisoners, in some cases, having to provide that care.
What was the inter relationship between the various factors involved?	Chapters Five and Six Discussion and conclusion	Complex patient pathways demanded effective and integrated commissioning. These are fractured by: 1. Healthcare Setting 2. Patients'

		Behaviours, Health and Outcomes
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A Case Study is not the pursuit of a research hypothesis. Rejecting the Foundationalist/Positivist position that a *stable reality* exists, this study embarked on a journey of active exploration of the *social reality* constructed through the lived experience of imprisoned patients in England. Via actively exploring the data within Thomas's (2011) key Case Study questions above, this study goes beyond the illumination of the lived-experience of participants only. It is also a fundamental requirement of Case Study Methodology, and crucially, this has enabled theory, the ultimate aim of this study, to be generated:

Equitable healthcare will not be experienced by imprisoned patients unless they are meaningfully engaged in the design and implementation of an integrated prison health and social care service strategy.

6.5.1 Why did it happen?

The policy narrative presented in Chapter One illustrated that a combination of effective lobby (Ramsbotham 1996), International and European Legislation enshrined in the *Convention for the Protection of Human Rights and Fundamental Freedoms (1950)*, NHS and prison-specific policy (Department of Health, 2004), created the conditions in which the ill health prevalent in this population was recognised. On its own, this situation was discomfoting but, coupled with the recognition that poor prisoner health was causally linked to re-offending behaviour and the wider health of the population, the Government was compelled to act (Joint Prison Service and National Health Service Executive Working Group, 1999).

6.5.2 How did it happen?

This policy focus provided considerable optimism for improvement. The energies and commitment of those championing the poor state of healthcare

had been both coherent and effective. Backed by clear legislation and Government funding, the key enablers of change were able to act.

There are numerous examples of effective change management models, and a number of these share common core elements. Those which appear regularly require:

1. Creating a vision for change
2. Communicating the vision
3. Removing obstacles
4. Embedding change in the new system/culture

Effectively communicated, the vision for change was first established in *The Future Organisation of Prison Healthcare* (Joint Prison Service and National Health Service Executive Working Group, 1999). This also required transfer notes and instructions to those charged with the implementation on the ground. The Ramsbotham interview for this study indicates that some of this, at least, was missing: “no guidance, protocols or transfer notes had been produced”, in the period leading up to the reassignment of responsibility.

There is an indication that PCTs understood little of their new patients’ needs (Health Services Management Centre, 2006). As a result, they were unaware of the significant *obstacles* existent in the system. Prison healthcare exists within a multifarious web of cultures, sub-cultures, formal and informal rules, attitudes, rules and norms as described previously. Therefore, unless change is driven in a manner which recognises, surfaces and works with these inherent barriers and opinions, there is a danger that the energy, effort and hard work of the new partnership will fail.

At the point of transfer to NHS responsibility, few PCT commissioners had entered a prison. This isolation was understandable in the early days, post-transfer, when one considers that prisons and the NHS had historically worked apart. It was, after all, one of the key reasons why the transfer was required and introduced. At a policy level at least, this situation was acknowledged.

The assessment of prisoner health need is of paramount importance and of relevance to this work. Participants (many of whom had serious long-term

health conditions) exposed in detail prison healthcare services lacking useful clinical information for those attempting to treat them. The Joint Task force and Health Policy Unit were intended to oversee the process of change as healthcare transferred to NHS responsibility. It would be interesting to establish whether assessment of need was monitored.

6.5.3 What was connected to what?

Chapter Two presented the health-related literature, thematically clustered, within the Government's Public Health Framework. Unusually, this material demonstrates a remarkable degree of consensus. Prisoners are widely recognised as a sick and disadvantaged community. Specifically, accounts of poor life experiences were widespread: physical and sexual abuse (Moran and Peterman, 1989), homelessness, mental illness (Hayward *et al.*, 2008), residence in children's homes or care setting (HM Inspectorate of Prisons Youth Justice Board (2009), poverty (Braveman and Gruskin, 2003), learning disability (Bradley, 2009), substance misuse (Fazel *et al.*, 2005), lack of education and school exclusion (Prison Reform Trust, 2003; The School Exclusion Unit, 2002) and risky behaviour (Stewart, 2009). This research has found wide support for these issues.

Many of this study's participants should not reside in prison, and the plight of those with mental ill health was particularly poignant: "They really shouldn't be in here Miss, this place just makes them worse", (male participant). Here too, there is support for the literature which asserts that prison does little to improve health and emotional wellbeing (Bradley, 2009; de Viggiani, 2007). Few voices only claim that incarceration delivers some limited benefit such as weight gain (Edge, 2006; MacDonald, 2006). For most, equity is something they have never experienced. A lifetime of abuse and addiction have instead created a profound sense of mistrust in many services. The long-term damage to individual health yields results which exceed the PCTs' ability to restore despite the optimistic intent behind the Public Health Framework.

The multifarious and complex needs of imprisoned patients have been clearly articulated in this study. Yet, the apparent disconnect between patients' needs and the services offered, or not offered, was striking. If equity is truly going to be achieved for this patient group, PCTs must effectively understand this. This

will require true engagement with prisoners, which has only happened in a limited number of establishments thus far.

6.5.4 What was the impact on imprisoned patients?

This study found that the Government's patient-centred policy has not been fully implemented within prisons. Imprisoned patients' healthcare needs are not effectively assessed, and patient-centred care is not thoughtfully provided on a consistent basis. Frequently, participants spoke of their experience of prison regulations, or the rapidity with which they moved around the prison system. According to them, the aforementioned issues at times take priority over their treatment needs, thus leading to detrimental impact on their health and wellbeing.

This was also found to be the case for those patients with acute or chronic health need requiring social care provision. It was not possible to determine which public service was responsible for funding adult social care for prisoners, and there is a clear need for this must be established. There is also a requirement for research and development in this field. Once identified, the funding to provide social care for chronically sick and disabled prisoners could be usefully combined with healthcare and other funding, in order to create a single budget. Through holistic commissioning, this thesis would suggest that it should be possible to secure services for imprisoned patients on an equitable basis throughout England, provided, of course, that imprisoned patients themselves are actively involved in both the formulation, and implementation of this work.

Although isolated pockets of equitable provision were found, it is essential that these now become mainstream within the NHS. Equity demands that all imprisoned patients should have access to the same level of care and treatment offered at the very best establishments. This will mean that some of the underlying behaviours and attitudes amongst both staff, and prisoners will have to be addressed. In those participating prisons where the governors were leading a respectful agenda, there was confirmation of a positive transformation in the underlying prejudice against prison/healthcare staff on the part of prisoners: "it helps that they seem to like prisoners here", was a comment professed by one female participant.

Being respected mattered substantially to participants and it was clear that, when encountered, this did much to restore their trust in individuals or the system. This contradicts general academic opinion in this area (Easteal, 2001; Howerton *et al.*, 2007). The authors assert that prior abuse leaves prisoners unable to trust figures of authority, yet the individual expressing her regard and trust for her current prison's staff featured above had herself been an abuse victim.

This study highlighted that provision of healthcare in prisons remains both complex and inequitable. In some prisons, the dedication of both NHS and prison staff are facilitating modern NHS provision despite chronic pressure of overcrowding. For others, the transfer to NHS responsibility has made little noticeable difference, meaning that the culture and practice have remained largely unaffected. A frequent participant view was that where poor attitude towards the health needs of prisoners exists, a simple transfer of responsibility would do nothing to remedy it. This highlights the complexity of the issue, and the notion of cooperation between these two public services.

It is clear that many people who commit offences have co-morbidities that were ill-addressed, and may have led to (many) being housed in prison because of a lack of appropriate care in the external community. The closure of specialised mental health units and transfer of care into the community is now widely recognised to have failed some of the most vulnerable members of our society (Shaw, 2007). As a result, Baroness Corston argued that:

Prisons are being asked to do the impossible... [and] Prison is being used to contain those for whom there is no proper provision outside prison, or who have already been excluded from society (Home Office, 2007, p.11).

In a thematic review of the care and support of prisoners with mental health needs, HMCIP (2009a, p. 7) argued that “prison has become the default setting for those with a wide range of mental and emotional disorders”. The Inspectorate argued that even if there were more and improved diversion scheme, there simply would not be enough space for those requiring this provision.

Further, HMCIP highlighted the lack of appropriate medical and nursing skills and training, as well as the failure to include improvements in health and healthcare, especially for people with learning disabilities in local PCT/prison action plans. It was noted that current practice fell short of requirements set out in the *Valuing People Green Paper* (Department of Health, 2001). Frater (2008) argued that the high risk of death for offenders whilst in prison is a Public Health concern. Rates of suicide in prison, she argued, are considerably higher than in free living populations worldwide, which “suggests that referral to prison may not be appropriate for some people and identify gaps in knowledge for healthcare professionals and policy makers” (Frater, 2008, p. 845). These findings supported Fazel *et al.*’s earlier (2005) study which found that the suicide mortality of men in English and Welsh prisons between 1978-2000 was five times higher than that in the general population.

It is interesting to note that participants in this study appeared to have no knowledge of the recent professional advancement of nursing careers. There was no understanding of the role of nurse practitioners. Instead there was a clear belief amongst prisoners that nurses provided a second-class treatment and were not qualified to care for them. Others believed they only existed to “block” their access to doctors. This is significant and could relate to the role of non-nursing qualified healthcare officers. These individuals would have only received six months training in healthcare, as well as prison officer training. There is clearly a communication problem here, and an opportunity for the NHS to demonstrate to patients in prisons the advances made in the nursing profession in recent years.

Further, prisoners complained that pre-sentence reports, or previously prescribed courses of treatment, were not carried out once the person arrived in prison. They also spoke about the delay, or non-appearance, of expert support promised and the complete lack of information they received about this. It was not uncommon to hear of clinicians contradicting one another, or checks against the prisoner’s record highlighting that support had not been requested from the appropriate agency or department, or treatment ordered. The vision for service integration which was central to the Prisoner Health Unit’s strategic vision in 2003 (Joint Prison Service and NHS Executive

Working Group, 1999, p.5), had been intended to do two things to improve prisoner health, as previously discussed in Chapter One. These were: firstly, to improve the standard of prison health services through greater integration with the wider NHS and, secondly, to improve *through care* utilising effective links with health and related community services. The findings of this study clearly indicate that these ambitions have not yet been achieved.

There were numerous examples of poor patient experience. For instance, dental provision was heavily criticised by participants, and is an area which is well documented in the literature. Harvey *et al.* (2005) called for high quality, fast provision for those with dental disease and those with urgent need. This study found few examples of improvement, and also some indication that rapid access to dental care was not the only difficulty. One member of the focus group reported waiting six months to see a dentist because there was insufficient money to employ a temporary replacement.

As a socially excluded group of people in English society, prisoners' health needs are wide ranging, generally high and related to the complexity and nature of this experience. In the community, there is provision of the full range of primary, secondary and specialist provision. Inside prison, there is essentially only a primary care service. This inequality exists not just between prisoner healthcare and that experienced by the external community, but also between the various prisoner sub-communities which live behind the prison walls.

If one were to consider the current order which exists for people who have the power and resources to access healthcare in England, then the educated, well-informed and articulate members of our society would be at the top. Ironically, this group is also the one which least often needs to access healthcare and contains the cohort of people often referred to as the *worried well* (Bowers, 1996). Below this group privileged social group, one's ability to access healthcare reflects the number of barriers a person needs to overcome in order to use the services available.

Here, it was identified that the disadvantaged, uninformed, uneducated, psychologically impaired/damaged, sick, frail, homeless, non-English

speaking, abused and people living outside the mainstream of society, all face, to varying degrees, hurdles which they must overcome if they are to access the care they need. The prison population is largely made up of these socially excluded people (Social Exclusion Unit, 2002).

6.5.5 What was the inter relationship between the various factors involved?

The theoretical position of this study emerges when one considers the inter relationship between the key themes and their profound impact on each other. This thesis asserts that:

Equitable healthcare will not be experienced by imprisoned patients unless they are meaningfully engaged in the design and implementation of an integrated prison health and social care service strategy.

In arriving at this conclusion, it is important to return to the Public Health Agenda which provided the theoretical framework for Chapter Two. It was posited that health promotion, health education, disease prevention and healthy settings are the key ingredients for health improvement. Equitable NHS provision was expected to be delivered within this framework, and this work is built on the assumption that, at least in theory, this is a realistic endeavour. This thesis, however, concludes, in relation to the second research question, that NHS policy has not been effectively formulated and practiced for this chronically sick and disadvantaged patient population.

There are numerous reasons for this, the first of which being a fundamental lack of knowledge on the part of NHS policy makers about the nature of this new patient population. Epidemiology, the study of the distribution and determinants of ill health in a given population is important here. Rodham (2010, p. 7) argued:

[...] the epidemiological perspective is a key component in identifying health needs, examining the pattern of disease problems within and between populations, searching for causes of disease, formulating health promotion and disease prevention strategies... and planning and evaluation of health services.

This important health-related investigation does not appear to have been conducted when prison healthcare transferred to the NHS. Indeed, there

appears to be evidence to the contrary, as it was argued that PCTs knew little of their new patient population, as previously discussed in Chapter One (Health Service Management Centre, 2004).

This research has also found that imprisoned patients construct their healthcare experience through a process of primary and secondary socialisation as outlined in the first section of this chapter. This is further impacted by their individual ill health. Taken together, imprisoned patients were seen to be active processors of prison healthcare provision, hereby supporting the social cognitive emphasis of health psychology. Fundamentally, this population constructed an individual and collective view of in- /equitable provision, and related this to their prison healthcare setting. Their views, once formed, determined whether individual participants were prepared to engage in health-related behavioural change. Without a willingness to do so, it is possible that the Public Health Agenda may not be effectively delivered in prisons.

In concluding this study, it must be questioned whether NHS policy makers took sufficient account of the prison healthcare setting. It must further be asked whether there was also an awareness of the entrenched imprisoned patients' beliefs and their subjective health-related norms. These created a powerful counter-force to the positive attempt to delivery Public Health benefit and equitable healthcare provision, aptly illustrated through the Tuberculosis disclosure previously discussed.

The work of Greenhalgh *et al.* (1998) is relevant here. The authors found that the successful treatment of people with diabetes required appreciation of the beliefs and attitudes of patients. They also identified that an understanding of the social networks of patients was similarly important.

This study would concur with this view. Indeed, without treatment effectively tailored to incorporate and build on the beliefs of imprisoned patients, health benefit will not be achieved. Further, such failure would represent an out-dated Medical Model of healthcare delivery which has been more recently replaced with the Biopsychosocial Model. Here, it is acknowledged that “thoughts, feelings, culture and environment can also impact behaviour

(Forshaw, 2002, p. 5). This research has gathered considerable data to support this.

Behind the prison walls, many prisoners struggle to cope with both tangible and intangible complexities, supporting many previous findings in the literature (Einat and Einat, 2000; Glaser, 1967; Kurtz, 1981; Pollock, 2006; Rosen, 1990; Wolff and Shi, 2009; 2004). Further, they must do so within a penal environment which was not designed with the complex ill health of its current population in mind. It is unsurprising, therefore, that significant gaps in provision were identified.

For a considerable number of the most vulnerable, particularly in male estate, imprisoned carers strive on a daily basis to provide the care required in the absence of recognition and support on anything other than an ad-hoc basis. The personal impact of providing this care on their emotional wellbeing and health is unrecognised. All too often the penal response was punitive, as in the case of a male participant providing medication to an elderly man with dementia: “they put me on a charge Miss”. However, when showering someone who had been fecally incontinent, he described, the prison was “quick to turn a blind eye”.

The following figure is the final graphic icon of this study and illustrates the diversity of caring within English prisons.

6.6 Implications for Policy and Practice

This thesis has identified the clear need for a multi-agency integrated prison health and social care service strategy. Imprisoned patients themselves should be included as full partners in both its design, and implementation. Without this, equitable healthcare provision will not be experienced by imprisoned patients in England. The importance of prison governors arose post-fieldwork, so there are no data collected. This issue, therefore, has been included as a future research recommendation rather than an analytical topic.

It is further recommended that the needs of imprisoned carers highlighted in this study are fully recognised and addressed. Significant additional research and development is, therefore, also required.

6.7 Concluding Remarks

In 2005, the researcher embarked on a research journey to explore and listen to imprisoned patients and stakeholders. This fieldwork took place in some of the most over-crowded and challenged prisons in England. The majority of these were not designed for the delivery of modern NHS healthcare.

During the research study, the universally poor health of this prison population was apparent. Thus, the policy decision was to strive for equitable treatment in the hope of improving its underlying ill health. This intention was recognised as inherently sound. This challenge has been met differently throughout England, and to dissimilar degrees in disparate prison establishments. In some places, the spirit and intention behind this policy were fully embraced. Here, modern NHS provision was designed and delivered to patients. This thesis suggests that, in others prisons, a lack of caring, inadequate physical estate, and open hostility amongst staff groups, have created a situation in which even the basic needs of the sick and disabled are not met. This variation is contrary to Government intent (Department of Health, 2004; Joint Prison and National Health Service Executive Working Group, 1999).

When system-wide change is attempted on this scale, it is essential that the public services learn lessons from the best examples of practice, and challenge where healthcare is found to be poor, or in need of further development. Here, the long-standing prejudice against this population enshrined in the *Principle of Less Eligibility* (Bowring, 1843) must be exposed and abolished, as the health of society is inextricably linked to that of the prisoner population. Prison health is Public Health since, here in the UK, very few persons remain incarcerated for life, as Ramsbotham (1996) aptly highlighted in his seminal paper.

It is, therefore, in society's interests to effectively treat the infections and blood-borne diseases prevalent here, for instance. Further, caring in a respectful manner for a prison patient population which has generally only experienced abuse and ill-treatment may do something to restore its trust and faith in humanity, as was found partially to be the case in this study. This must be welcome, as most imprisoned patients will shortly return to live in the community at the end of their sentence.

For some, equitable prison healthcare will perhaps not provide the complete answer, as numerous social exclusion issues also exist. Healthcare is not the only need for this population. This study indicates that it is not acceptable for society to imprison some of its most vulnerable members arguably due to the Care in the Community policy failure. The lack of secure therapeutic environments is a national shame (Bradley, 2009; Shaw, 2007; Yorston, 2004), and the words of Howard (1784) echo through the years "[...] no care is taken of them, although it is probable that by medicines, and proper regime, some of them might be restored to their senses and usefulness in life". Alone, the NHS cannot resolve this since, by the time that many reach the prison gates, it is already too late to restore their health and wellbeing. This prisoner group requires multi-agency intervention.

Equitable provision must, therefore, start in the community and the impact of the Inverse Care Law (Tudor Hart, 1971) must be addressed. Facilities are required for the learning disabled (Bradley, 2009), vulnerable women (Home Office, 2007), addicted (HMCIP, 2009) and mentally ill (NACRO, 2007; Ramsbotham, 1996). It can no longer be accepted that prisons are a place of residence when the system elsewhere fails. The Social Care Sector in particular is required to step forward and assume its responsibilities for this community. Many require personal day-to-day assistance and social care. This may require significant investment and reform.

Commencing at a time of record investment in the NHS, this study is published six years later. This is a time of substantial financial constraint which will impact all areas of public service. It is essential that the hard-won gains in prisoner healthcare are not lost. This is particularly important when the role of many organisations, including PCTs, will be considered and

abolished. Learning from the best will be vital to support new commissioning arrangements going forward.

Looking back at this study, it is posited that the key to producing effective and lasting change in this environment is to ensure that imprisoned patients themselves are empowered to play a full and effective role in this change process as much of the solution rests with them.

This study identified the positive impact that governors, prison officers and healthcare staff could have on negative attitudes, by being prepared to do something different for patients in their care. Those governors who facilitated direct access were making a tremendous difference to the daily experience of patients, simply by being prepared to listen and respond flexibly within the security environment.

The establishment of the Healthcare Forum at one prison had made a dramatic difference to the previously negative attitudes of imprisoned patients. Patients and staff were working together within the group to shape healthcare around the needs of their community, and this had led to some innovative and modern approaches to treatment and delivery. The prisoners, who said they had been previously sceptical about the initiative, felt they had *ownership* of the forum, and that it had addressed and broken down prejudice and barriers.

The women's focus group likewise, spoke of the difference effective partnership could make. This had transformed the experience and attitude of members of the healthcare group at the prison.

6.8 A Final Thank you

In conclusion, the researcher would like to express profound gratitude to everyone who participated and granted access to their complex, and often challenging, world. It is hoped that, by taking part, individual voices will be represented, analysed, and amplified via this research. It is hoped that participants feel they have been given the opportunity to be effectively heard.

6.9 Limitations

There are several limitations to this work, and these will now be discussed in relation to its content and chosen method. In considering what this research adds to the body of prisoner healthcare knowledge, it is important to reflect on the literature review of this thesis. Areas of methodological strength and limitation, and knowledge development relating to the academic field of interest will first be discussed.

6.9.1 Study method reflection

This study aptly acknowledges that it is double-hermeneutic (Duncan, 2005). Multiple perspectives of reality, therefore, exist and the researcher's interpretation of the data is inherently embedded (and constructed) within her own social context.

As previously described, O'Connell Davidson and Layder (1994, p. 169) posit that, whilst conducting qualitative analysis, the viewing of data through this social and cultural lens can result in researcher bias via the "imposition of preconceptions and stereotypical assumptions". Therefore, to generate meaningful theory within an interpretative case study approach, developing constructs were actively considered in relation to this relevance with the data.

Further, the use of Colazzi's (1978) framework, undertaken in tandem with these reflections, ensured that participants' own words formed the basis of this knowledge. Consideration of the data, and not the researcher's own verbalisation of these phenomenon, therefore, limited biases or pre-existing expectations. thus preventing, where possible, the generation of untrustworthy research findings (Holloway, 2008; Polit and Hungler, 1996).

The fundamental tension between this and Yin's (2004) argument that, within the case study approach, the researcher's explicit preconceptions and assumptions are a distinct resource is acknowledged. Indeed, the researcher's 20 year-experience in the carer-support field doubtless made her receptive to the data indicating that prisoners were acting as carers in the penal environment. Yin's theory finds considerable support here. Such a belief,

however, must be held in balance to avoid the danger of preconception (O'Connell Davidson and Layder,1994).

This was overcome in part, via active and consistent reflection of the research data gathered, back to participants. At each phase of this study, participants have validated its *fit* with their own perception of prison NHS provision, thereby, ensuring congruence of emergent themes, experiences, and constructs, of the varied groups and interviews.

However, a further limitation to the study's chosen method is acknowledged. Participant correspondents contributed a significant body of data. The researcher's interpretation of this was hindered by participants' poor literacy, for instance. The method adopted did not allow for the researcher to ask this participant cohort to validate her interpreted understanding of their written text. In an attempt to overcome this, correspondent data was reproduced as received throughout this thesis. For some participants, poor writing skills did not present an insurmountable barrier to participation. Many wrote well, as demonstrated in the findings chapter.

Poverty amongst prisoners' families is acute (Joseph Rowntree Foundation, 2007). What is less recognised, however, is the level of extreme poverty amongst the prisoner population itself. This became apparent during this study. The foresight to include a freepost address proved helpful (although this was an uninformed, but fortunate consideration).

Much has been written about prisoners' lack of trust, as previously discussed. Unwittingly, this study benefitted from having initially approached participants through their own newspaper *InsideTime*. Female Focus group participants commented that they had previously read about the study in this way. This, they said, would have earned the study considerable respect. As a result, they felt people would be willing to talk to the researcher.

To remove any risk that participants were unable to understand the complex research themes emerging from this work, a graphic artist was employed to represent these pictorially. This also proved successful. It is accepted, however, that multiple interpretations of this material may be formed.

To conclude these initial reflections, the researcher recognises her underlying knowledge and role as a social actor in the field. It is further acknowledged that other researchers may generate other interpretations or knowledge via this thesis. This is certainly encouraged. The penal environment is recognised to be difficult to access (Liebling, 1999; Patenaude, 2004), and this study benefitted from the generous support of a limited number of governors. It is the researcher's hope that others entering this field will also benefit from these actions. To facilitate this, an extensive quantum of the data gathered from Phases One to Five of this study has been included in this thesis. Other researchers may find this valuable for their own analysis and reflection.

It must be recognised, however, that there are important limitations to this data which must be considered by those who may wish to use it. Ziebland and McPherson (2006) challenge researchers to reflect whether only those who had been easy to contact had been included in their work. For example, prisoners who do not receive NHS healthcare were excluded from this work. This strategy was deliberate and is not, therefore, a limitation to its methodological approach and used sample frame.

However, in relation to Young Offender Institutes, this exclusion is acknowledged to have been unintentional and, as such, is problematic. Young person correspondence and semi-structured interview to some extent proved a valuable substitute, thus highlighting a particular strength of the iterative nature of the Case Study methodology adopted. It remains unknown whether a Young Person Focus Group, and the inclusion of female young offender perspectives, would have enabled yet further research themes to be identified.

Participants were a self-selecting sample and the impetus to take part may have been influenced by any number of factors. Here, a poor experience of healthcare was the motivating factor for many. This was not the case for all, however. Female focus group participants reported excellent care in their current establishment. They remained anxious to participate to share this and their wider experience of the prison healthcare system. For the young offender interviewee, experience in his final establishment had also been positive.

Participant culture and sub-culture proved complex. Much of this is evident in the earlier chapters of this work. Observing interaction during focus group meetings, it was clearly apparent that a power differential existed between individuals. Whether this prevented the less able to freely express their views is hard to establish. It must, however, be considered a possibility. These observations also demonstrated the care and compassion participants showed to the frail elderly within their number. This proved a key strength of the focus group method employed.

Regarding epistemology, this thesis constructs knowledge via visits to participating prisons, fieldwork interviews and participants' correspondence, representing 75 social settings. May (1998) raises a number of reflective concerns, and these help identify the boundaries and limits of this study's *knowledge*. Social researchers must, therefore, submit to critique their varied ways of thinking about the world (May, 1998). Hence, reflection requires that the researcher recognises that attempts to *mirror* reality are futile. It must be asked, therefore, whether anything can be *known* from this work. This requires further consideration of the research data.

Prisoners' experience of healthcare in England post-transfer to NHS responsibility has been previously recognised in this thesis to be a convoluted construct. It only debates the contributions of those participants who *chose* or were *enabled* to share their views. Had this study included other participants recognised as missing from this research, it is likely that, to some extent, its analytical discussion would have differed in both content and conclusions.

Likewise, the large sample of participant correspondents did not enable the identification of demographic characteristics. Analysis was constructed on the entire body of participant data (including all groups and interviews). The exploration of sociological characteristics for individual participating cohorts, although not the intention here, would have generated other interesting debates and considerations for social researchers in the field. On reflection, these additional insights may have been beneficial.

6.9.2 Study content reflection

The knowledge presented in this research was generated in the initial chapters from four distinct areas of interest:

1. Equitable healthcare policy intent (Joint Prison Service and National Health Service Executive Working Group, 1999),
2. Equitable healthcare policy implementation within the Public Health Agenda (Department of Health, 2002a) together with PSO 3200,
3. Primary Care Trust delivery responsibility (Department of Health, 2004),
4. Gaps in existing knowledge about prisoner health and their healthcare experience.

Numerous areas of consensus and disagreement have been explored and highlighted throughout.

A deficiency in space and lack of alignment with this thesis' healthcare focus meant that wider discussions were not included. Debates surrounding *transinstitutionalisation* (Prins, 2010), prison sentencing policy (HM Chief Inspectorate of Prisons, 2009; Johnson and McGunigall-Smith, 2008; Prison Reform Trust, 2008b), mental health and learning disability (Bradley, 2009), and the possible emergence of a potentially *subjective norm of prisoner health* (Ajzen and Fishbein 1970, 1980) are recognised as important, however, for this study's participants. Each offer valuable avenues for future research.

In addition, the analytical discussion of this work both corroborated existing academic opinion as, for example in the case of prisoner bullying and provided counter knowledge in others. This was found to be particularly the case in relation to the make-up and purpose of pseudo-families, alcohol use and the wider health benefit of imprisonment.

These, and other debates included in this thesis are interesting. Nevertheless, the Case Study methodology selected demands that a conclusion is drawn to this research within the boundaries established. It will be for other researchers, should they so chose, to explore the issues highlighted beyond this point.

Therefore, final reflections demand that this study must reflect the content of this work thus far, and its position within the wider health policy of the future. In so doing, it is important to return to the Public Health Agenda which provided the theoretical framework for Chapter Two. Within this, equitable healthcare for English prisoners was required to be delivered (Department of Health, 2002a). Participant's perceptions, previously outlined, identify that this has yet to be fully realised. But, will it be so in future?

6.9.3 Thesis postscript

Chapter One presented the vital importance of effective NHS policy and legislation for the benefit of imprisoned patients. These final reflections, therefore, demand that this thesis' content should be considered in relation to an emergent key piece of NHS legislation, the *Health and Social Care Act 2012* (Great Britain, 2012) which was, published on 27th March 2012.

The prior efforts of prison philanthropists and healthcare policy makers have been presented and critiqued throughout this research, particularly in its opening chapter. Also debated has been the challenge for healthcare providers who are charged with delivering equitable NHS healthcare within an environment ill-suited for this purpose. The fundamental underlying tension of *custody versus care* features as an omnipresent tension.

Considered from its end point, the content of this thesis would suggest that these demands are fundamentally incompatible. Indeed, a radical solution along the lines of the actual merger of prison, health and social care as a single unified provider dedicated to the provision of security, care and rehabilitation of prisoners may ultimately be required. Thus, the emergent conflict between staff groups, and prisoner healthcare experiences highlighted here, may be avoided.

A number of analytic debates confirm that prisoners' health is a neglected topic in England. Indeed, there is a long history of incarcerating the mentally ill and sick (Howard, 1784). Post- release, however, prisoners return to live amongst us, carrying with them their experience and untreated conditions (Ramsbotham, 1996).

The *Health and Social Care Act 2012* (Great Britain, 2012), therefore, was presented with an opportunity to do much to substantially build on the early limited health gains long fought for by those included in this thesis.

Now, driven by the *Localism Agenda* of the coalition Government, £60 billion of patient treatment funds are being transferred to Clinical Commissioning Groups (CCGs), thus signalling a return to a belief that *doctor knows best* previously highlighted in this research. At a theoretical level, it must be considered whether this raises a threat to the Biopsychosocial Model of healthcare, and a return to the Medical Model previously practiced.

Also, at a theoretical level, the responsibility in future to deliver public health benefit will now become the responsibility of Local Authorities. Regulation 6C (Great Britain, 2012) states:

“1) Regulations may require a local authority to exercise any of the public health functions of the Secretary of State (so far as relating to the health of the public in the authority’s area) by taking such steps as may be prescribed.

2) Regulations may require a local authority to exercise its public health functions by taking such steps as may be prescribed...”

This requirement is being placed on these local bodies at a time when they are challenged by a level of funding cuts unprecedented in their history, alongside the loss of Primary Care Trusts (previously responsible for equitable service delivery to imprisoned patients).

Further, the content of this thesis would suggest that the current political concern for the *local* creates a danger that broad system-wide changes necessary for equitable prisoner health may be lost.

Therefore, as a result of the fieldwork, reading, and analysis undertaken for this thesis, it is suggested here that these issues should be debated at the earliest opportunity.

6.10 Study Development

The exploration of offender experience of equitable healthcare via the fieldwork and adopted study process has provided the necessary research skills to establish a Research Division within Carers Federation Ltd. Further, the acquired knowledge of the health experience of this marginalised community, in tandem with the aforementioned skill set, offer a number of valuable avenues for potential policy development and follow-on study.

A research study which develops the embryonic knowledge of the complex world of imprisoned carers is of merit. The interpretative methodological approach remains valuable and the wider exploration of why people chose to take on this role within the penal milieu is of worth. Regarding a follow-on study, the theoretical framework outlined below seems apt.

The writings of Ervin Goffman (1974) and Gregory Bateson (1972) formed the basis of frame analysis. Both authors explored how individuals used metacognitive devices during social interactions in order to understand the situational issues with which they were presented. Frame analysis represents a valuable methodological framework to understand:

- “What sorts of conceptual and contextual interpretive frames do we place around situations and what sense do we make of them?
- How are meaning and understanding constructed?
- What classifications do we use to frame different kinds of communication/situations and to shape our social lives?” (Grbich, 2007. p. 47).

Thus, understanding how frames structure carers’ realities, and how these are applied within diverse prison settings and circumstances during social interaction merits investigation.

In relation to this study now concluded, the inherent risk to both carer and cared for identified thus far cannot be ignored. These matters relate directly to risk analysis at both a policy, and local establishment level, and must not be subservient to the proposed prison ethnography outlined here.

How caring is practiced within prison is valid for future research work. How the risk inherent in the caring relationship is recognised and mitigated has equal value. Therefore, by simultaneously applying the prison risk analysis framework to the recommended study's findings, policy can be safely and appropriately developed for these vulnerable individuals.

Publications arising from this Thesis

Community Spirit and Honour among Thieves – Health Service

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Appendix A

Key Publications and Instructions of Relevance to Imprisoned Patients

Source: Department of Health

http://www.dh.gov.uk/en/Healthcare/Offenderhealth/DH_4032016

Legislation

Care Standard Act 2000
Criminal Procedure (Insanity) Act 1964
Data Protection Act 1998
Disability Discrimination Act 1995
Health Act 2006
Health Protection Agency 2004
Health and Social Care Act 2003
Human Tissue Act 2004
Medicines Act 1968
Mental Health Act 1983
Mental Health Act 1983 - Code of Practice 1999
Mental Health Bill 2006
Mental Health Capacity Act 2005
Misuse of Drugs Act 1971
National Health Service Act 2006
National Health Service Redress Bill 2005
National Health Service Reform and Health Care Professions Act 2002

National Instructions

PSI 05/2003 Good medical practice for Doctors providing primary care services in prison
PSI 05/2005 Re-introduction of disinfecting tablets
PSI 07/2002 National Service Framework for diabetes: standards
PSI 09/2006 Rationalisation of doctors duties in prison
PSI 16/2003 Strategy for modernising dental services for prisoners in England
PSI 21/2001 National Service Framework for older people
PSI 23/2003 Model protocol providing access to medication by non-healthcare staff
PSI 24/2002 Health promotion in prisons: a shared approach
PSI 25/2002 protection and use of confidential health information in prisons and inter-agency information sharing
PSI 27/2000 Caring for the Suicidal in Custody
PSI 28/2003 Pharmacy Services for Prisoners
PSI 29/2003 Clinical Appraisal for Doctors Employed in Prisons
PSI 36/2002 Developing and modernising primary care in prisons
PSI 38/2002 Guidance on consent to medical treatment
PSI 38/2003 Basic checks on Doctors and Dentists
PSI 43/2003 Issue of Healthcare Skills Toolkit
PSI 46/2003 Medical Treatment of Prison Staff by Healthcare Workers
PSI 47/2003 Rationalisation of Doctors' Duties in Prison
PSI 48/2003 Guidance for the Introduction of Healthcare Assistants
PSI 50/2001 Hepatitis C: guidance for those working with drug users
PSI 69/2000 Basic checks on doctors and dentists

PSI 138/2003 Basic checks on doctors and dentists
PSO 0200 HM Prison Service Standards Manual
PSO 1300 Clinical governance: quality in prison healthcare
PSO 1301 Investigating deaths in prison custody
PSO 2855 Prisoners with disabilities
PSO 3050: Continuity of healthcare for prisoners
PSO 3100 Clinical Governance-Quality in Prison Healthcare
PSO 3200 Health Promotion
PSO 3500 Health Promotion
PSO 3550 Clinical Services for Substance Misusers
PSO 9020 Data Protection

Publications and Guidance

Guidelines for the clinical management of people refusing food in immigration removal centres and prisons – August 2009
Offender Health and Social Care Strategy Data Report – March 2009
Guidance notes: prison health performance and quality indicators – March 2009
Independent evaluation report of Improving health, supporting justice: a consultation document – August 2008
Common themes from analysis of 120 Prisons and Probation Ombudsman (PPO) reports – May 2008
Escort and bedwatch costs: transfer of funding from HM Prison Service to primary care trusts – March 2007
Prison Health Partnership Survey 2006: Final report – March 2007
National partnership agreement between the Department of Health and the Home Office for the accountability and commissioning of health services for prisoners in public sector prisons in England – January 2007
A twelve-month study of prison healthcare escorts and bedwatches – November 2006
Reconfiguration of NHS Ambulance Trusts – implications and protocols – September 2006
Performance management of prisoners' health services – April 2005
Transfer approval process – April 2005
Signposting to prison health: learning from Wave 1 Transfer – November 2004
Health services for prisoners: Prison Service performance standard 22 – May 2004
Prison Health Services – letter from Peter Lawler of the Welsh Assembly Government and John May of HM Prison Service – April 2004
Guidance on developing local prison health delivery plans – October 2003
NHS responsible commissioner for prisoners update – June 2003
Transfer of prison health to the NHS update – March 2003
Guidance on developing prison health needs assessments and health improvement plans – January 2002
An insider's guide to the NHS and prison service: unlocking the jargon – January 2002
Healthcare in prisons: a health care needs assessment – February 2000
Toolkit for health care needs assessment in prisons – January 2000
The future organisation of prison health care – March 1999

Mental Health Specific

Lord's review of people with mental health problems or learning disability in the Criminal Justice System
Mapping Mental Health Interventions in the Juvenile Secure Estate

Promoting mental health for children held in secure settings: a framework for commissioning services – March 2007

Mental health observation, including constant watch observation – good practice guidelines for healthcare staff working in prisons _ August 2006

Changes to benefit entitlements for patients transferred from prison to mental health units – 2006

Procedure for the transfer of prisoners to and from hospital under sections 47 and 48 of the Mental Health Act 1983: guidance document – November 2005

Offender mental health care pathway – January 2005

Mental health services and prisoners: a review November 2003

Mental health in-reach collaborative launch document – November 2002

Chancing the outlook: a strategy for developing modernising mental health services in prison – December 2001

Safer prisons report: A national study of prison suicides 1999-2000 – May 2001

Primary and Social Care

Information for prisoners with a disability – June 2009

Report of the Working Group on Doctors Working in Prisons

Provision of FP10 and FP10 [MDA] prescription forms by HM Prison Healthcare for released prisoners: guidance (for England only) – March 2008

Medication in possession: a guide to improving practice in secure environments – August 2005

A pharmacy service for prisoners – July 2003

A pharmacy service for prisoners Q&A brief, recommendations and implementation plan – July 2003

Substance misuse and the Integrated Drug Treatment System

Guidance for the pharmacological management of substance misuse among young people

Guidance for the pharmacological management of substance misuse among young people in secure environments

A guide for the management of dual diagnosis for prisons – April 2009

Integrated Drug Treatment System for Prisons (IDTS) allocations for 2009/10

Integrated Drug Treatment System for Prisons (IDTS) allocations for 2008/09

Clinical management of drug dependence in the adult prison setting including psychosocial treatment as a core part – December 2006

Integrated Drug Treatment System for Prisons (IDTS) Budget 2006/07 – July 2006

Public Health

Impact of DH-funded provision of NRT in HM prisons: revised findings – May 2006

Stop smoking support in HM prisons: the impact of NRT, executive summary and best practice checklist - May 2006

Good medical practice for doctors providing primary care services in prisons

Clinical supervision in prison nursing: getting started – August 2002

Clinical governance for prison health: a discussion document – January 2001

Patient and Public Involvement

Patient advice and liaison services (PALs) for prisoners: dear colleagues letter – October 2005

Prisoners' access to PALs and ICAS: dear colleague letter – October 2005

Workforce, Including Education Training and Development

Guidance document for healthcare professionals entering HMPS establishments – October 2006
An education and training framework for staff providing healthcare in prisons – October 2006
Agenda for change for prison healthcare staff – September 2006
The HR in the NHS plan: a prison workforce perspective and briefing – March 2005
Prison health induction framework – November 2004
Recruitment and prison healthcare: guidance for staff recruiting healthcare staff – 2004
Retention and prison healthcare: guidance for effective retention of healthcare staff – 2004
Healthcare Skills Toolkit – July 2004
Prison nursing: NHS careers fact sheet – July 2004
Personal learning plans: the doctors working in prison guide – February 2004
They're not just patients or prisoners. They're people (leaflet) – January 2004
NHS agenda for change – March 2003
Nursing portfolio – January 2002

Information Management and Technology

Prison Health IT programme: national roll-out
When to share information: best practice guidance for everyone working in youth justice system – May 2008

Appendix B

Literature Sources Accessed by this Study

AMED

Article First

ASSIA

CINAHL

Cochrane Library

Credo Reference

Department of Health

Google Academic

High Wire Press

HM Chief Inspector of Prisons

HM Prison Service

Home Office

House of Commons

Integra

Medline

Ministry of Justice

Net Library e.books

Open University Members Electronic Library

Oxford Journals

Prison and Probation Ombudsman

Prison Health Trust

Prison Reform Trust

Prison Research Network

PubMed

Times Digital Archive

UK/EIRE Reference Centre

University of Nottingham Electronic Library

Appendix C

Department of Health Permission



Skipton House
80 London Road
LONDON
SE1 6LH

Julia Tabreham
CEO
The Carers Federation
Unit 2.1 Clarendon Business Park
Clumber Avenue
Nottingham
NG5 1AH

30 January 2006

Dear Julia

Prisoners experience of healthcare in England

Thank you for your letter setting out your plans for your PhD studies which sound extremely interesting and, I am sure, will ultimately provide some much needed evidence to support service improvement. The Department would be very pleased to receive findings from your research as soon as you are ready to share them.

I am more than happy for you to access material from the 'Options for Implementation of ICAS in Prisons' report. Can I suggest that you contact individual prison governors for permission to work in their establishments, rather than going through national or regional structures, as this approach worked very well when collecting data for the Options report.

I look forward to hearing more about your work as it progresses; in the meantime please let me know if we can help in any way.

Good luck.

A handwritten signature in black ink, appearing to read 'Meredith Vivian'.

Meredith Vivian OBE
Deputy Director, Responsiveness and Accountability
Patient and Public Empowerment

Cc: Anita Harris, ICAS Project Manager

Appendix D

Guidance Notes for Group Sessions

Prisoners' Experience of Healthcare in England Study

Script for focus group sessions:

Thank you for responding to the posters placed around the prison and indicating that you would like to participate in this validation group session. The role of a validation group is very important to a study of this kind and you will be looking at issues raised by previous participants who have written to the researcher. The researcher will be asking you whether you feel the issues raised make sense to you as a user of healthcare in prison. You will be invited to give your opinion about each of these and they will be discussed in-depth.

The study you are participating is intended to last for five years and people are being invited to take part to share their own experience of using healthcare services in prison. This is the second year of the study. At the end of the three years this study will be published and the findings will be made widely available.

We are going to be looking today at your experience of using healthcare in prisons, and I would remind you that other people are present in the group so you should only talk about those things which you feel would be safe to discuss in the presence of others. We will not be looking at individual healthcare complaints in this session.

I am going to show you the issues people have already raised as important to them and have brought these with me on a large poster. I will present each of these in turn, however, please do not feel constrained by this and raise any issues you feel relevant to this study should you wish to do so.

The researcher will take care to ensure that you will not be identified in the study and that everything you say will be entirely anonymous. All research material will be stored on a secure computer system at the Carers Federation Head Office and will not be accessed by anyone other than the researcher. After publication of the study all records will be destroyed.

It is essential that you feel entirely comfortable to take part in this session and do not feel under any kind of pressure to participate. Before we start can I invite anyone who would like to leave the group to do so.

I would like to thank you for your interest. I will also be making a more detailed thank you once the study has been completed in InsideTime and will let everyone know the results of work.

Appendix E

Participant Invitation

1. Invitation

You are being invited to take part in a research project. Before you decide to participate it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask if anything is unclear or if you would like more information.

2. Purpose of Project

The aims of this research project are to explore the following questions:

- How do prisoners experience health within prisons?
- What has been the impact for prisoners of the transfer of prison health to Primary Care Trust responsibility?
- Is the experience of prisoners using healthcare within prisons accurately recognised by those agencies responsible for their care and treatment?

3. Why am I being invited? Do I have to take part?

You have been invited to take part in this study because your establishment is in the prison category selected for this study, participation is voluntary and if you choose to take part you may discontinue participation at any time

4. What will happen to me if I take part?

If you choose to take part in this research study you will be asked to attend a focus group session which will last for approximately one hour. You will be in a group of approximately 10 people who are also housed in your establishment. The researcher and a colleague, who will be there to take notes, focus group will ask you to describe any aspects of your care and treatment within prison healthcare. It is essential that you should only share what you are comfortable saying in front of other people in the group.

5. What are the possible disadvantages and risks of participation?

You must ensure you feel completely comfortable in taking part in this research study. It is essential that you do not take part if you feel under any pressure whatsoever to take part. The research will check with you again at the group whether you would still like to take part and will inform you about the purpose of the study again also. At this point or at any time during the discussion you must feel free to leave the study should you wish to do so.

By taking part in this study you will have an opportunity to inform everyone who reads the research report about your experience as a patient in prison. It will give you an opportunity to make your voice heard.

6. Will my participation be kept confidential?

All data collected for this study will be stored in locked files and on secure computers at the Carers Federation offices. The company is registered for

storage of sensitive data and is fully responsible of its responsibilities to protect data under the Data Protection Act. The Carers Federation has been awarded an externally audited quality mark for its work and has achieved ISO9001-2000. All information collected from participants in this study will be kept confidential and you will not be identified as an individual in any report or publication arising from this work.

7. What will happen to the results of the research project?

This is a five year study and the researcher is currently half way through this period. Once results have been analysed a report will be written and published. The researcher will publish a further thank you to participants and details of the findings in InsideTime the prison newspaper. The data collected for this study will be destroyed 12 months following publication of the work. Should you wish to obtain a full copy of this study please contact the University of Lincoln following publication.

8. Who is organising and funding the research?

This research study is being undertaken at the Centre for Clinical and Academic Workforce Innovation, the University of Lincoln and has been funded by the Carers Federation.

9. Reward

There is no financial payment for participating in this study.

10. Contact for further information, including questions about the research and participants' rights.

For further information please speak to either:

The Healthcare Governor or the researcher Julia Tabreham at The Carers Federation, Unit 2.1 Clarendon Park, Nottingham NG5 1AH 01215 9856677.

If you would prefer to speak to someone else contact Professor Tony Butterworth at the Centre for Clinical and Academic Workforce Innovation, University of Lincoln.

11. Thank you

Thank you for your interest in this study.

Please retain this information sheet for your further information.

University of Lincoln
Centre for Clinical and Academic Workforce Innovation

**WOULD YOU LIKE TO PARTICIPATE IN A RESEARCH STUDY
LOOKING AT PRISON HEALTHCARE?**

**I am looking for volunteers to take part in a study of patients'
experience of healthcare in prison**

**As a participant in this study, you would be asked to join other
interested women in a small group to talk about your experience
of using healthcare services in prison**

**Your participation would involve one session on 5th October 2007
which will last approximately one 1 hour and no payment will be
made for participation**

**The session will explore any issues group members would like to
discuss in relation to using healthcare in prisons. Individual
healthcare complaints cannot, however, be discussed at the
meeting**

**For more information about this study, or to volunteer please
contact:**

XXXXXX

XXXX

at

XXXXXXXXXXXX

**This study has been reviewed by, and received ethics clearance through
The University of Lincoln**

Appendix G

Validation Group

In February 2007 the researcher visited a male prison for the purpose of validating the initial results from the study.

Despite the current strain on staff resources the governor welcomed the researcher to the prison and organised the focus groups personally. The governor also took the time to show the researcher around a typical cell on the older person's wing and arranged a meeting with the head of healthcare. Prior to contacting the prison, the researcher had faced considerable difficulty in accessing prisons with letters sent requesting access either being ignored or access refused. On one occasion a short reply was received which stated *"we already know we have problems we don't need you to come here and tell us about them"*. Others expresses concern that the study would highlight problems within their prison and draw attention to these, this in turn leading to a negative impact on staff morale.

Having finally gained access the researcher met two groups of 10 prisoners on the older person's wing to discuss 14 research themes already identified by a participant's letter to the study, and provide an opportunity for participants to validate or disagree with these.

When each group was convened the researcher explained again the purpose of the study and the importance of the group to the validity of the research. A commitment was made not to identify individuals within the study. Participants were advised they could change their mind about participating at any point. One person in the first group chose to leave prior to the start of the discussion when he was informed that the researcher would not be able to listen to his individual healthcare complaint.

The researcher highlighted the 14 key issues identified by prisoners who had participated in the study and invited group participants to share their own experience in relation to these. Issues raised by validation group participants are presented below:

Need for Thorough Assessment of Health Needs in the Courts

Group participants spoke of the complex health issues many patients have in prison and how unaware the court system is currently of these. Lack of assessment at the early stage of entry into the judicial system, meant that prisons were largely unaware of the health needs of their future patients, and often ill-equipped to cope with some of the acute or multifaceted care needs of individuals who are imprisoned. It was felt that a thorough assessment during the court process would enable needs to be identified, documented and advised to those people charged with the future care and treatment of that patient. It was also felt this would go some way towards preventing admission into inappropriate

establishments which were not equipped or able to care for prisoners who had conditions which required specialist provision or expertise.

(Nodes: Medical records)

End of Life Care

At the time of the visit, one patient from the wing was receiving palliative care in a local hospital and was nearing the end of his life. The group spoke about the difficulty prison healthcare faced when trying to provide palliative care in a setting which was not designed for this. As an older group of prisoners the group was aware of other people with terminal conditions, and felt this would be increasingly common with an ageing prison population. Participants spoke about their close bond with other patients on the wing, and how difficult they found it when someone was dying. They felt there was a need for specialist care and treatment in purpose built facilities on site. The opportunity to die outside the prison walls should be available they felt and could be preferable to ensure patients ended their life in appropriately equipped facilities and with dignity and respect. One group member spoke about having had given the kiss of life to a prisoner who was unwell and collapsed on the landing.

(Nodes: Treatment/Access to specialists)

Dentistry

Prisoners spoke regarding their difficulty accessing dental treatment. They believed the current prison overcrowding was creating a lack of capacity. Several group participants were aware that dental provision outside prison was also an issue of concern to the general population at the current time too. Group participants asked about the number of dentists currently employed by the prison service and whether this was likely to increase to enable the prison to cope with the additional demand prison overcrowding placed on the system. One participant expressed his fear that appointments would need to be booked a year in advance to ensure getting in to see a dentist. Tooth abscesses were of particular concern for the group with many of the participants having had an abscess or knowing someone else who had one. Access to emergency dental treatment, they believed, is an issue throughout the prison service and very difficult to access. One man commented 'Dentist, I waited seven months to see him and two teeth fell out during the time, I never did get to see the chiropodist.' Another man spoke about an 80 year old unable to eat due to abscess. 'Dentist went on holiday for a month but there was nobody to cover.'

(Nodes: Waiting times/Access to specialists)

Specialist Care and Treatment

A number of participants spoke about the difficulty prisoners faced when trying to arrange any treatment of a specialist nature and spoke particularly about access to opticians and chiropodists. They were interested about the transfer of commissioning of healthcare provision to Primary Care Trust responsibility and

asked whether this meant that the prison patient population would now be entitled to *“the same care as people outside?”* One man said *“physiotherapy is a really big issue we have to wait months for treatment and equipment”*.

(Nodes: Access to specialists)

Hospital Treatment

The group expressed a wide difference in opinion about how easy it was to access hospital or specialist treatment. One prisoner was full of praise for his own care, having received an operation for spinal fusion within six weeks of his initial hospital appointment. Prisoners raised concerns about the way in which hospital appointment slots are currently allocated and the difficulty in matching these to the availability of prison escorts to take the patient to the hospital for treatment. Recent changes in the way hospital appointment slots are offered to prisons was adding to the difficulty and it was feared would lead to a backlog of untreated patients. One patient spoke about his own difficulty in getting an eye operation and his belief that this would have been done within six weeks if he was a member of the general population.

(Nodes: Access to specialists)

Discrimination

There was a strongly held belief in the group that patients in prison are discriminated against by external medical staff. They felt the reactions of medical staff deteriorated once they became aware the patient was a prisoner. A number of group participants felt strongly that they were discriminated against by external healthcare professionals if they came from sex offender units.

(Nodes: Healthcare staff)

Medication

The lack of access to strong pain killing medication was endorsed by the group as a particular issue for patients in prisons. The common practice of prescribing of paracetamol for acute pain was highlighted as insufficient for patient's needs. Opiate based medication was cited by the prisons as interfering with drug testing programmes and this was considered to be the main reason for refusal to prescribe these.

Participants also said it was common practice in prisons to double dosage in response to increased pain or other symptoms which could have a knock on effect to other medication being taken or their general state of health and wellbeing. One man said *“there's a tendency to double medication and you end up on a cocktail without review”*.

(Nodes: Medication)

Prisoners Acting as Carers

Group participants spoke about the informal caring networks which exist within prisons. The ageing prison population and increasing number of people who are now sent to prison has led to increasing numbers of people with complex medical issues. Group participants said that one man on the wing had had a heart valve fitted at the age of 80. Although it is not officially allowed for prisoners to administer medication to others it was described as common practice in prisons throughout the country for people to do this. It was particularly the case if the patient had a condition such as Alzheimer's disease or other impaired cognitive function.

Group participants spoke of the close bond they formed with the people they cared for and the lack of support available in a prison setting for people taking on caring responsibilities. Sometimes caring for another person could take place over a number of years until the person being cared for was either released back in to the community or died in custody.

The group also felt that vulnerable patients in prison were at risk of abuse. This would be the case where frail or cognitive impaired prisoners required assistance with social care tasks such as showering and going to the toilet.

(Nodes: External support)

Medical Information

The group confirmed the current difficulties surrounding the recording of accurate medical information. Previous medical notes are not readily available although these can be requested. There is a charge for this and many prisons are, therefore, reliant on the medical history given to them by the prisoner when they arrive. This is acknowledged to present difficulties on a number of fronts. Some of these are many prisoners claim to be taking a range of medication which they are not currently taking. Medication can be used as currency in prison and access to as much of this as possible can boost the income of a prisoner considerably. Some patients with sensitive medical issues would prefer not to disclose this to prison staff members. Group participants said they then told other prisoners about these and one patient cited being told by someone he had Tuberculosis in this manner. Often patients keep health issues private and hidden from both prison and healthcare staff.

Confidentiality of care and treatment was also raised. Prison healthcare staff were prevented from disclosing the nature of a patient's complaint to prison staff due to patient confidentiality. Patients felt this was difficult for everyone and predominantly so for prison staff who had to care for patients on the wing with no knowledge about their underlying medical condition and treatment regime.

One man commented *“I had to have a heart attack before anyone got access to my medical record”*.

(Nodes: Medical records-assessment)

Health Assessment

There was considerable concern about the lack of health assessment within the prison system and group participants felt this was mostly needed at transfer request point. The rapidity with which patients moved around the prison system also complicated the medical records issue further. Patients often arrived at their new establishment well before any record from previous establishments did, so leading to a break in continuity of care and treatment. Group participants felt there was a need for a review for each patient to establish a complete picture of health and this should be reviewed on a regular basis.

(Nodes: Medical records – assessment)

Disabled Prisoners

Many group participants had chronic health and mobility issues; a number of people were wheelchair users. The group spoke about how difficult it was to be a prisoner with a disability within an environment which was not designed to house them. Tight space in cells or on the landing made it very difficult to get around using a wheelchair. It was also difficult to house specialist medical equipment which was required to support some patients with complex or palliative care needs in prison. A number of group participants felt strongly that some prisoners abused the system and claimed to require a wheelchair when they did not in fact need to use one.

Others said this was not generally the case, and there is an increasing number of disabled or frail elderly prisoners who do require wheelchair support.

(Nodes: Healthcare facilities/treatment)

Compensation Culture

A number of group participants felt there was a strong compensation culture amongst prisoners with inmates suing for ‘anything they felt aggrieved about,’ some repeatedly. Prisoners are entitled to free legal support throughout their sentence and many made full use of this. Participants felt that fear of being sued led to healthcare staff being overly cautious in their treatment. This led to the same old tried and tested treatment and prescribing being continually offered.

(Nodes: Treatment/Healthcare staff/Complaints)

Proactive Care and Treatment

Participants felt strongly that prisoners should be allowed to be proactive with their own health in prison. They explained that living together in a confined space meant that any infections present would spread rapidly through the prison *“Illness*

spreads like wild fire in here". One group member said he felt that if he was aware someone on his wing had a cough or cold, he should be allowed to be proactive with his own health and purchase cold remedies to ward off any possibility of him catching it. He said that if he was outside the prison in the community he would be able to walk down to the chemist and purchase any over the counter medication.

It made no sense to him that a similar facility wasn't available in prison.

(Nodes: Treatment/Medication)

Diarrhoea

The group painted a graphic picture of what it is like to be in a confined space with other people when diarrhoea is prevalent on a wing - it was impossible to escape the smell. Again prisoners felt they should be allowed to purchase over the counter remedies to prevent them developing this. There was a strong belief amongst all group participants that over the counter remedies were effective. Some elderly cognitive impaired prisoners were regularly incontinent the group said.

(Nodes: Medication)

Access to Healthcare

One of the biggest problems group participants experienced with prison healthcare was the length of time it could take to get escorted to and from the healthcare units, *"it takes five minutes for your appointment and one and a half hours to get an escort to take you back to the cell"*. Participants were very unhappy that elderly patients had to go outside in the rain to the healthcare department or on occasions wait outside in such conditions to see the nurse when they were sick. One participant was unhappy that *"nurses turn up at 10 and turn everybody out to work"*.

One member of the group said that he felt *"nurses in the prison were under unbelievable pressure"* and he didn't *"know how nurses cope with some of them"*.

There was a strong feeling amongst the group that prison was not the appropriate place for sick elderly patients. They complained that strong young men would demand attention and this would often be given as a means of controlling situations which authorities feared could get out of hand. One patient said he could cure prison overcrowding and all the problems in the system *"in one fell swoop"* this he felt could be achieved by *"letting everyone over the age of 65 go"*.

(Nodes: Healthcare staff/Prison regulations/Healthcare facilities/Access to specialists/External support)

Being Handcuffed in Public

Participants said it was acutely embarrassing to be handcuffed in public when receiving medical attention. Instances of very sick people being handcuffed in

some cases to two officers were cited. Group participants felt that when someone was not in a physical position to 'run' they should not be handcuffed. This would allow them to access healthcare like the rest of the community and not face the adverse reactions of both other patients and the medical staff at the hospital or other treatment facility.

(Nodes: Privacy/Healthcare staff/Prison regulations)

Security

Healthcare in prisons participants said was affected greatly by aspects of the prison regime. A regular occurrence would be a 'lock down.' At these times nothing either enters or leaves the prison and if someone is in need of medical attention this has to wait until the situation is stabilised. Group participants cited a case of a doctor waiting outside the prison walls for 20 minutes during a lock down and felt that something should be done to prevent this happening. Numerous suggestions were offered to include: doctors and other urgently required medical staff to be allowed into the prison regardless of the current security situation; healthcare to be facilitated outside the main ground of the prison; specialist onsite medical emergency treatment facilities to be provided in each prison, with round the clock medical provision; a prison hospital wing to be provided in all prisons.

One group member commented *"If ships at sea have to have a full time doctor with less people why don't we?"*

(Nodes: Prison regulations/Healthcare staff/Healthcare facilities)

Inflexibility of the System

A number of men complained that the restrictions they faced when trying to access external care and treatment had led to people learning how to play the system, *"if we wait until Sunday afternoon when healthcare staff aren't about and collapse we are able to get the hospital treatment we require as there's nobody else to take care of us"*. Everyone in the group was aware of this and again this was presented as a common reaction to inflexible healthcare within the wider prison system.

(Nodes: Prison regulations/Access to specialists)

Long-term Health Conditions

The group commented that elderly prisoners in particular were likely to suffer from long-term medical conditions. One participant was a diabetic and said that prison was a very difficult environment in which to control his condition. He was now suffering from loss of sight and also sensation in his limbs. Prison food was cited as a particular cause of this deterioration.

(Nodes: Healthcare facilities/Prison regulations)

Work Duty

The group was unhappy at being made to work whilst sick.

(Nodes: Prison regulations)

Conflicting Demands of the Young and Old in Prison

Participants said that young fit inmates got preferential treatment by healthcare staff or were treated more quickly as a means of containing a situation which could pose a security risk. The young, they felt, could be demanding and aggressive with healthcare staff who would often let them leap the queue to ensure wider trouble did not flare up within the prison. One man commented that *“elderly prisoners’ health needs suffer because of young ones. Them that shout loudest get treated first”*.

(Nodes: Healthcare staff/Treatment)

Nursing in Prison

There was a lot of dissatisfaction in the group about nursing in prisons. Many group participants felt nurses blocked their access to see the doctor. It was believed by participants that *“different nurses tell you different things”* and that *“nurses are over stretched and under resourced, making decisions that they are neither trained for, nor resourced to do”*. This perception was held strongly in the group and when one man said *“people who don’t know think they are medically trained”* this was readily endorsed by the others.

(Nodes: Healthcare staff)

Pressure on Healthcare Due to Prison Overcrowding

The current overcrowding in the prison system was leading, the group felt to pressure on healthcare *“they’ve doubled the size of the prison but we don’t have twice the number of doctors”*. Prison recalls were blamed for much of the increase in prison numbers. One man commented that there are *“a lot of people inside who shouldn’t be in here. One man recently returned because he broke parole. The parole office had been shut and he phoned to say he was unable to register but they arrested him anyway and he’s back inside now”*.

Other group participants commented there are a lot of people in prison now who *“wouldn’t have been in for ‘what they’ve done’ years ago”*.

With longer sentences many of them were growing old in prison and facilities were not provided to care for their conditions and treatment needs.

(Nodes: Healthcare facilities)

Emergency Treatment

The group spoke about their fear of needing urgent medical attention whilst in prison. The security constraints meant there were a lot of doors for medical staff

to get through and cited a time when *“it took two minutes longer for healthcare staff to travel 70 yards across a prison to treat a dying man than it took the paramedics to reach him by ambulance”*.

Prisons they felt were not the place for the acutely ill and many older prisoners were constantly concerned that if they collapsed they could die in their cell. Some prisoners spoke about times when they had given the kiss of life to other inmates during their time inside and the close bond they form with each other. They were acutely aware which participants of the group were at risk of a heart attack or other conditions, and not only feared losing them but having to face watching them collapse without being able to do anything to save them. The authorities were applauded for letting one member of the group attend a recent funeral dressed in a smart suit to represent the prison when a man collapsed and died on his landing. He also spoke of the irony that when he himself became very ill and required a hospital appointment for an MRI scan a little time later; he had to attend the appointment handcuffed and escorted by three officers which he had found acutely embarrassing.

(Nodes: Prison regulations/Healthcare facilities/Access to specialists)

Suggested Solutions

Before concluding, the researcher asked the group whether they could suggest anything which would make the current situation better for patients in prisons.

One man suggested that prisoners should be allowed to sign a disclaimer to say they wouldn't sue. This he felt would enable healthcare staff to *“provide more holistic care”*.

Training for informal carers was suggested as something prisoners would benefit greatly from. Currently they are not allowed to care for each other in prison in any official sense which is leading to them administering medication in secret and without medical backup. They are also showering and taking to the toilet the very sick and frail, and believed their own health and wellbeing was being adversely affected. The situation should they felt be openly acknowledged and the necessary support and backup provided to those providing the care to others within prison.

(Node: New Node identified Caring in Prison)

Lock down shouldn't prevent access to medical staff during an emergency. This should be the same for prisoners who have appointments with healthcare staff or specialists, *“we should still be taken to them”*.

Specialist treatment for the elderly in prison is required, preferably on the wings themselves. A hospital wing within prison was suggested as increasingly necessary. The provision of specialist facilities for the elderly in prison was also suggested.

Regular review of care treatment and medication was also said to be in urgent need of attention.

Validation Group Conclusion

Participants endorsed the 14 thematic clusters (*nodes*) and said that they were comfortable with these as a reflection of the issues they experienced within prisons. The researcher felt confident, therefore, to proceed to the next stage which was the focus group discussions.

The following section details the findings of the male focus group discussions.

Appendix H

Men's Focus Group

Similarly to the prison in which the validation group took place, the Governor at Focus Group A prison also welcomed the study. This prison had a Patient Healthcare Focus Group which had been running for approximately one year and the researcher was invited to talk to participants of this group.

Due to the complexity of the data gathered so far the researcher took along a graphic artist who had pre-prepared a large board with the *nodes* drawn around the edge. During the discussion new information was added to the picture creating a graphic depiction of prisoners' experience of healthcare in their time in prison.

Focus Group A. Discussion

One participant felt that at his current prison there was good efficiency in getting external appointments and usual waiting times was two to three weeks.

'Lifers' were believed to get a better deal. One of the patients, himself a lifer, believed the preferential treatment was due to the category. This he believed carried a certain 'status.' The Category A status patient is required to be escorted everywhere getting access to meals and healthcare more quickly. It was claimed that to escort a Category A status prisoner 18 miles from the prison costs £25,000.

(*Nodes: Access to Specialist and Waiting times*)

Participants had had experienced poor healthcare during their many years in prison. Overall the group felt that patient experience of healthcare in prisons is generally bad. Participants agreed that healthcare services were better in their current prison.

(*Nodes: Waiting times/Healthcare staff/Healthcare facilities*)

In previous prisons participants said that waiting times were: optician one year; this was cited as one participant's first-hand experience when he broke his glasses; waits to see the dentist were reported to be six months or more in many prisons.

This contrasted with their current prison where waiting times were only weeks and not months as elsewhere.

Participants felt this was good. They also praised the excellent healthcare staff at the prison.

(*Nodes: Healthcare staff/Waiting times*)

One participant spoke about his previous prison induction experience where the doctor didn't assess the patient, *"he didn't even touch me"*.

A participant recalled at another prison his own assessment had consisted of just checking his *"height, weight and date of birth"* then he added *"another patient did it!"*

At another prison one patient said the GP on 'sick parade' just sat behind a desk wearing his coat. Participants agreed they thought this issue and was due to a poor attitude towards patients who are in prison.

(Nodes: Healthcare staff/Treatment/Medical records - assessment)

Participants felt that GPs had a bad attitude which leads to patients in prison giving a bad attitude back. This results in the patient getting *"nicked"*, patients felt that they *"can't do anything"*.

(Nodes: Healthcare staff)

Patient records were of concern to participants. One participant reported his healthcare records had been delayed by a week. Another participant said his healthcare records were lost within two days of being in HMP X, he added that they were later found. It was reported that the participant's current prison requires an IMR (Instant Medical Report form). Without this form prisoners are refused admittance.

Participants said that the medical record system was bad generally and this created increased risk for patients as it could lead to not getting correct medication or treatment.

(Nodes: Medical records – assessment/Treatment/Medication).

One participant said that in HMP X methadone had been prescribed for dentistry problems. He felt that if the patient had never experienced opiate based painkillers then this would be bad; paracetamol he said would have been sufficient.

(Nodes: Medication/treatment)

Participants felt that random drug testing at their current prison was a good idea which they supported.

(Nodes: Illegal drugs)

Group participants said they had seen big changes in provision in the past 18 months at their current prison. Participants said this was due to proper management and a widespread change of staff.

Patients commented that it hadn't always been good in the past. New staff members had been very carefully picked.

(Nodes: Healthcare staff)

Participants said the healthcare staff at their current prison were good at listening and had a *"good caring attitude"*.

The group also felt that the establishment of their Healthcare Forum was leading to positive changes in services at the prison. *"We now have a diabetic clinic and an asthma clinic - these came from issues raised in the Patient Healthcare Forum"*. Participants felt happy with their flexible clinics which again they had personally had an active role in shaping.

(Node: Treatment/Healthcare facilities/Access to specialists)

Patients agreed that they were now receiving a better treatment because of the recent changes [in the healthcare department].

(Node: Treatment)

One participant said that before the change of staff he had to wait five weeks without insulin and it took the threat of him contacting his solicitor before the prison provided the appropriate medication. One man said he had previously kept his own stock of insulin saved up for such incidents; he knew that he would get 'nicked' if this had been found but felt it necessary to store this and he felt lucky that he had done so.

(Node: Healthcare Staff/Medication)

Participants were very critical of staff who had been at the prison before the changes. *"Staff didn't provide any dignity or care of patients before change"*, patients now felt that their new better staff had improved the patient/healthcare staff relationships. Group participants were amused to note that the last [healthcare] complaint at their current prison had been about a toothbrush.

(Node: Complaints/Healthcare staff/Treatment/Privacy)

Participants said that it was not uncommon for patients to hide their medical conditions from healthcare staff but they didn't tend to do this from each other.

(Nodes: Healthcare staff/Privacy)

Patients were happy that their Healthcare Forum had been established. They said the Forum *"helps shape the service"*. Participants noted that they had *"a stake in the service"* and felt valued. It allowed *"patients who have any resentment to have their issues raised at the Forum and have a voice"*.

Participants agreed that there was a difference in the medication received at different prisons: to resolve toothache, HMP X dispenses paracetamol and HMP X dispense methadone. Previous experience was that sugar free methadone was not offered to people with bad teeth which caused them further problems. No choice of medication was offered.

One had noted that actually in prison some healthcare issues which prisoners came in with have been resolved and it had not been possible to do this on the outside.

Better medical staff at the prison had made a real difference. This was felt to be the case for both doctors and nurses.

The insistence on the best possible staff within the prison had led to a requirement that prospective staff were expected to visit the prison at least two or three times prior to interview. If they failed to show any other interest in the prison they did not get an interview. Participants said they are expected to show a keen interest. A close working relationship had developed between the prison and students from the local School of Nursing.

(Nodes: Healthcare staff)

Patients advised that in other prisons if they went to the doctor with an illness the doctor would only discuss that specific issue and refuse to look at any other conditions or concerns.

(Nodes: Healthcare staff/Treatment)

Participants noted a number of changes since their transfer to NHS provision, in particular they now had access to evening clinics and Sunday clinics which they advised were very good.

Another welcome change was that patients were now issued with 28 days' worth of medication each time. Patients were happy with this. The flexibility in dispensary opening times was appreciated by patients because they were not now having to miss a day's pay.

When asked by the researcher whether, when sick, they saw themselves primarily as patients or prisoners the group said "*patients*".

(Nodes: Variation of healthcare provision/treatment/Prison regulations/Dispensary opening times)

Across prisons, group participants felt that treatment was not the same; some prison wardens treat patients like 'scum' and had a bad attitude towards patients. This would be general in the prison and not simply confined to the healthcare department.

At the participant's current prison waiting times were generally praised as being:

- External appointments – easy access, short waiting times;
- Alcoholics Anonymous meetings, patients can easily attend;
- Dentist – fortnight;
- Optician – fortnight;
- Chiropodist – fortnight

One lifer patient advised that he was embarrassed at a recent dentist appointment as he was talking to another patient from prison who had been waiting months for the appointment when his own wait for treatment had only been two weeks. He also said that it is usual for some prisons to take months to get an external healthcare appointment, however waiting times here are very good.

Licences are required to go outside to external appointments; occasionally this was why waiting times longer; a lifer patient also advised that he was issued a licence for one appointment but when he got there he was a week early.

The prison was also working towards its own purpose built building for healthcare, with de-fibrillation treatments and staff trained to use the equipment if required. Thorough examinations of patient at time of complaint reduces future costs, e.g. if given a thorough examination by a dentist this could save the prison £800 per month.

(Node: Waiting times/Healthcare facilities/Treatment)

When asked by the researcher whether they had access to external support patients said they felt that social workers are 'do-gooders'; they expressed that they had a reluctance to get involved with 'these people.'

Patients, however, spoke of good relationships between patients and healthcare staff, and said they felt an element of trust between them. They believed they could tell 'them' issues rather than wanting to see external specialists. Patients said they felt they were treated like people.

Forum members were in agreement that patients at their current prison were treated like people and staff were flexible to individual needs.

(Nodes: Healthcare staff)

Patients also felt that privacy was very good at their current prison; in their experience not all prisons have this and in some it is non-existent. Patient recalls at HMP X there is a yellow box that you are not allowed to enter at healthcare if you cross the box you get 'nicked.'

(Nodes: Privacy)

Forum recently managed a random drug testing unit, 200 prisoners tested 26 positive which is below average. Treatment for people with drug misuse issues is approached by looking at the whole person. Patients felt they were not pushed into treatment outlined in the detoxification programme, but given an assessment. Healthcare works with patient to make sure the right treatment/medication is provided to person based on individual assessment and requirement, this also to prevent drug misuse when moved back onto the wing. The prison has employed a GP with specialist interest for drug users to help.

(Nodes: Illegal drugs)

Participants believed the Healthcare Forum provides the members with credibility with other patients. Things seem to get done.

Patients recognised that access to external specialists was good and that this was unusual elsewhere. Group participants expressed their gratitude to NHS staff who staff the night clinics, they felt this was being done to 'help patients' and they were appreciative of them giving their time up.

(Nodes: Healthcare staff/Healthcare facilities)

Participants said that the Forum members were volunteers, anyone who wanted to attend could join any time; the group runs once per month. One member commented that improved healthcare facilities can lead to a reduction in patient deaths. One of the reasons for possible deaths in prisons was *"patients not getting proper treatment and patients not getting staff and medical help in time"*.

The group noted that patients in resettlement could wear their own clothes on external visits and feel more comfortable.

A patient advised that he had high blood pressure was overweight and a smoker, he confirmed that he didn't get any treatment until he arrived at his current prison and had received a lack of assessment previously.

The prison was at that time trying to secure an end-of-life/geriatric service at the prison looking to get high dependency beds but was experiencing problems securing the funding.

Patients agreed that there is a caring community within their prison.

(Nodes: Healthcare facilities/Access to Specialists/Healthcare facilities/Treatment/Medical records and assessment)

Appendix I

Women's Focus Group

The Governor arranged for the researcher to meet a group of women to discuss their healthcare experience.

When the group was convened the researcher explained again fully the purpose of the study and the importance of the women's experience to the research. A commitment was made not to identify individuals within the study. Participants were advised they could change their mind about participation at any point.

Women's Focus Group Discussion

The majority of women in the group were serving life-sentences and informed the researcher that they had experienced prison healthcare in a number of prisons. Some of the women in the group had read the request for research participants placed by the researcher in *InsideTime* in September 2008. They were in previous prisons at the time and said they had written to the researcher about their experiences. The researcher had received neither letter. The women said that they weren't surprised to hear the letters had been blocked as they had been critical of their prisons.

The women spoke about the lack of a methadone maintenance programme in women's prisons which puts up the cost of care.

(Nodes: Illegal drugs)

Women they felt took better care of each other - because they are women, they care for women.

(Node: Node caring in Prison – generated by the men in the validation group)

Participants spoke about family groupings in women's prisons and said these could be extremely violent.

(New Node: Prison Sub-cultures)

The women spoke about healthcare staff they had encountered in previous prisons at this point and what a dreadful experience it had been. One participant commented *"they don't like prisoners, the treatment you get at X and X the dentist just ripped a tooth out and left a gaping hole in my mouth"*.

(Nodes Healthcare Staff/Treatment)

"I was really sick when I came here but my medical notes were missing. When I came here though, they got me to a hospital straight away and sorted it. They also got me to dentist he went oh my God! Got to remove the tooth you've got an

abscess the size of a football, seen the dentist here, sorted out infected tooth, left a huge hole – in the end he had to take it out. Got a huge gap in my gob got here and they did it as quickly as they could. One appointment got lost in the post from X, glad it was here otherwise I would have been had it done while there and would have been handcuffed”.

(Nodes: Medical Records – Assessment/Treatment)

Another participant said “I had a hysterectomy. I’d been really sick for three years and I had a breakdown. I was in such a state. When I started to get better, I had the operation as soon as they could get it sorted. I finally had the operation, they took the sutures out in the hospital and it was infected. I stayed for nine weeks and had a hernia because they hadn’t put my muscles back together and they had gone by the time it was sorted. They tried to put some mesh across my stomach but I got another hernia down the bottom and they can’t do anything with it now because of the time lapse since I was in X. They said if I had been sent to hospital earlier it wouldn’t be so they might have been able to do something.

(Nodes: Variation in Healthcare Provision/Treatment)

“No one takes you seriously if you have a condition that doesn’t manifest outside its all internal. I had such problems trying to convince people there is something wrong with me. It took about a year before they took me seriously. You have illness but keep trying to be normal”.

(Node: Healthcare Staff)

“I have got X Disease [name of disease deleted due to extreme rare nature of this condition and concern that participant would be inadvertently identified if stated] for about four years. I went to hospital for an MRI in handcuffs but for three years in prison I wasn’t able to go outside to my own doctor. It can be really stressful. I ended up with 14 years. Every time I went to a legal visit it’s more stress. You don’t know what’s going to happen”.

“You expect to get sentenced but the people around sometimes in the prison they make things worse – they tell you different things and you get more and more stressed. It’s hard to get any consistent advice”.

The women felt their best source of support was other women in prison and repeatedly commented *“women stick together”*.

(Node: Caring in Prison – generated by the men in the validation group)

Women in the group said *“Here you can access healthcare but in closed you do try and help and support each other. Staff are not going to let them go to healthcare. It’s a two to three hour wait in a cage and then they’re asked ‘what the fuck’s wrong with you!’*

There's the support from women. X and X are both as bad as each other anyway. Lots of self harm at X".

(Node: Prison Regulations)

"They only support you because you're a figure – a statistic".

(Node: Mental Health)

"I have asthma; they didn't care at my last place, night staff are supposed to come round 6 or 7pm. I was really ill after my operation, if couldn't get there I couldn't get there. The nurse had gone home with my asthma meds in her pocket as she was too frightened to come out with it. Sometimes two other women used to hold me up so I could get down for my meds".

"There were often errors on the list for meds and if you're not on the list for meds you don't get it. I'm on sleepers because I'm bi-polar – if I don't sleep you'll have a bastard in the morning".

"You were supposed to line up at 8.15 am and it took 15 minutes to get there. There would be about 30 people queuing for dispensary, so 15 minutes with a half hour queue and we would then get nicked for being late at work".

(Nodes: Medication)

"They don't apply for your records. I got home leave in 2003 and went to see my local GP to ask if there's any way my previous medical history could be sent to the prison. I was really sick but they hadn't applied for it. They didn't request it from the hospital either. There was a record at the hospital that nothing had ever been requested. No one ever asked for it and hadn't for two and a half years".

(Nodes: Medical Records)

What about people with learning difficulties and mental health issues?

"They don't know what's going on and get really bad".

(Nodes: Mental Health/Learning Disability)

"Got here from X over on medical grounds; they thought I was going to die [patient with mental health issues], they put me on different medication. It's taken me two years to get myself back together, in my head because of their neglect".

(Node: Mental Health)

What do they do right here?

“They’re concerned about you”.

(New Node: Prison Staff)

“I should be on much stronger medication but you can’t take it in here”.

(Node: Medication)

“Healthcare here are much more relaxed and willing to help people in here they work with everyone, in other prisons they don’t. It helps that they don’t mind prisoners here”.

“They’ll talk to you”.

“I can get a hug”.

(Node: Healthcare Staff/Prison Staff)

“X’s is really nice. Within 24 hours I had three months supply of my meds. It’s horrible standing with them fuckers. They have a box. You put a note in the box if you need your meds”.

(Node: Medication)

“You have their trust here; it makes a real difference”.

(Nodes: Healthcare Staff/Prison Staff)

“I was a nurse in my first life, looked after 90 people, 70 you give a shot and say bloody junkie – take it and piss off. You distinguish between needy, those who never used drugs. Some would get a script and re-offend”.

“Only time you get help is if you’re in that category. If not forget it you’re on your own”.

“Meth’s far more dangerous than heroin – if you can get off Meth – it’s so hard to get off. Substitute Meth and give heroin – it’s cheaper”.

“By 8.15 get up to their end of prison, most of the time it’s over. No communication with healthcare staff or doctor. Got a 20 bed rehab at X, released on temporary licence – give out MDT (mandatory drug test)”.

“Decriminalise drugs and regulate and tax them”.

(Node: Illegal Drugs)

"The healthcare here, I've got no problems with it".

(Node: Healthcare Facilities)

"It's really hard to access 'well women' treatment. If you want anything sorted then they'll deal with it here but in closed prisons there's not got much of a hope".

(Nodes: Treatment)

"I spent about 17 months on the waiting list to see the optician and dentist. Here it's much better to go out to do it. I can go out unescorted".

(Nodes: Access to Specialists)

"They can't just give free licence to everyone to do as they like. Once someone takes advantage it starts reflecting on everyone. They need to be not risk assessed in the appropriate manner".

"A lot here are genuine".

"Once in here you get to know them. You get a feeling if you'll be able to go out soon on a different visit if she goes, will she come back? It's scrutinised".

(Nodes: Prison Regulations)

"Everyone I meet has a drug and alcohol problem".

(Nodes: Illegal Drugs)

"If you've managed to get to open they need to know how ready are you to go back in to the community. Unless any issues you have are addressed you'll never improve healthcare for the rest of the population".

"Larger rate of depending in female estate than men, and women suffer more with mental health, suicide".

(Nodes: Mental Health/Illegal Drugs)

"In X my Temazapan was taken away. I only got 20 minutes sleep a night for months – they thought I was trying it on. I had a breakdown and saw the psychiatrist too late".

(Nodes: Mental Health/Medication)

“Could not see doctor, optician or dentist coz on remand, it’s really unfair. X is a private sector prison you couldn’t access anyone”.

(Nodes: Access to Specialists)

“I asked for an asthma spray it was supposed to last a month but only lasted a week but if needed it at four in the morning the officer told me I would have to use a paper bag. I was really scared and asked them what I would do if I had an attack in the night they told me ‘don’t call me, call an undertaker.’ An officer heard it and reported that nurse and I didn’t see her again. But they still didn’t give me anything and there was no way to sort out, they didn’t give a shit. They didn’t really care at all in healthcare at X. This has been the only place that’s helped me. They’ve got me on the right medication so I don’t have to take steroids”.

“Had a headache – had a pain – doesn’t matter what the problem is take paracetamol”.

(Node: Medication)

“I had a horrendous time with healthcare. I put in a complaint on how to treat prisoners with a disability. I was threatened with being sent back to a closed prison but told them you can’t treat people differently just because we’re disabled. I threatened to sue them but it took a long time to sort things out – it took a very long time. Some of the nurses have gone now”.

“I said I need to get out a bit and go to work if not prevented to”.

(New: Node: Disability Issues)

“The problems were a lot to do with the old staff”.

(Node: Healthcare Staff)

“Sometimes you can be really ill. I had a drop down X attack [removed to maintain anonymity of participant’s identity] whilst talking to one of the officers”.

“One lady was really ill and spent hours in reception while they were deciding whether she’d stay or send her back because they didn’t have the facilities to care for her. You have to be mobile up and running, and functioning or you can’t go. Being in prison doesn’t mean you can have a quality of life. She said this was common”

(Node: Healthcare Facilities)

“I wanted to kill myself but I improved when a ‘Listener’ listened to me. I talked to her and if not for her I would be dead. She’s left now but we’re still close. Couldn’t have coped I could see no way out. She was my mate – she wanted to stay to help me. I got no help from the prison system and collapsed in X. I got diagnosed

with diabetes, there's so little provision for women. I collapsed a few times and they saw me through the door and said 'someone's down.' But they don't go in your room to pick you up they wait till the morning when they unlock and come in to this".

(Node: Mental Health)

"If you collapse in your cell they don't pick up because of lock down".

"In this prison it's a good healthcare service".

"It reflects the prisoners' big picture in here and a good service is given. They don't have drug addicts. Not on drugs then got dependant on drugs had to have Valium. I've seen people get so used it they had to grab the sides of the walls or bars to get along to get their drugs. How wrong is that! There's about X women in prison".

(Node: Illegal Drugs)

"Sometimes when I was sick I could ring a bell for hours and would not see anyone come round to see what was the problem".

(Node: Healthcare Staff)

"If we don't subscribe to what's on offer you go down as non-compliant. It's all about ticking boxes, if you don't tick them you don't get parole. You have to go on offender behaviour courses there's no assessment for it so to tick their box we are told to do it".

"The bureaucracy in the system is mad!"

(Node: Prison Regulations)

"Loads of women here are serious drinkers"

(New Node: Alcohol Abuse)

Appendix J

Semi-structured Interview Young Person – Transcript

It had been the original intention of this study to visit a young offender institute and speak to young people about their experience of healthcare, however, the researcher again experienced significant difficulty in trying to do this. Approaches to a number of establishments were either: refused, ignored or on one occasion granted then later ignored. After discussion it was decided instead to conduct an in-depth semi-structured interview with a young offender who had been recently released from a young offender institute. It was believed that by doing this the researcher would gain access to someone who had a wealth of experience to offer to the study and whose access was not blocked by the establishment.

The following is a transcript of the interview which took place on Monday 25th June 2007.

Researcher - Can you tell me how you experienced healthcare when you were inside X young offender institute?

Young person – *“Firstly I experienced quite a lot, they health checked me when you go in, basically they just asked you a lot of questions, how you are? It’s not like a physical or anything but I had a couple of issues just small things like I had trouble with my eyes and went to the opticians because they have an optician in there. Also I used to go to the gym a lot and I strained..... I can’t remember the muscle but it was the muscle around my elbow. I went to the doctor, I think reasonably quickly and he referred me to the physio. They put me on a training scheme down the gym to help me. Also before I went in I had a lump on my testicle as well and so I was worried about it so I went. I didn’t have time before I went in to get it checked out so I went and had that checked out by a doctor inside and he referred me to the Infirmary. I went to X Infirmary and they scanned me and said everything was ok. They told me I didn’t have cancer or anything, and if I had any further problems to go straight back to them”.*

Researcher - Just out of interest, before you went in to X why didn’t you get it checked out?

Young person – *“Well, I dunno, I was a little bit scared to be honest. It just seemed like an opportunity to get it checked out. It was also a chance to get out and see a bit of the outside world”.*

Researcher - When you went to the Infirmary, what happened about your medical records? Did your medical notes come back to X Young Offender Institute? What happened?

Young person – *“Yeah, I’m trying to think about that. I don’t know where they went, there was two officers that were accompanying me and I don’t know whether*

they handed them any documents. I'm guessing they didn't and they just sent them".

Researcher - How did you get to find out about your results?

Young person – "Well, the best of it was it was on the spot they told me at the Infirmary it wasn't cancerous. I don't know if you know but a lot of gents get cysts and it was just that".

Researcher - So when you went back into X Young Offender Institute did they offer any kind of follow-up in clinic?

Young person – "No just the infirmary told me and that was it. No I didn't see the doctor at X Young Offender Institute but I did see doctors while I was there I saw two of them".

Researcher - Do you have any idea whether there was a regular change of doctors at X? How long were you there?

Young person – "Um I saw while I was in there two over the two years I was there, but I saw other people. There was quite a lot of healthcare staff and I mean a lot of them were nurses. They were nice they were, there were a large amount of units. And there was a pharmacy there. They used to come down to the units and if you was sick they used to dish your medicine out. And generally they would come and see you at night time if you'd got a problem then you got locked down in your cell for the night and you were there till morning. Yeah so they will come to you but obviously if you were about to die and screaming in pain they should come. There was this guy though he ended up having appendicitis he ended up screaming behind the door in his cell. Obviously you can't see who it is but the guy was obviously in a lot a lot of pain and in fact they didn't let him out, I think they waited till the morning, then they got him straight off to the hospital that was really bad".

Researcher - What happens in situations like that where there is a sudden crisis with somebody's health?

Young person – "It just depends. Once you've gone into your cell I'm not sure if it's the Governor's say whether they let you out again. But if you have a bit of an attitude and there's an officer you don't get on with then they're not going to be particularly helpful to you. I never really put a foot wrong in that place coz obviously they were the key to me being all right and if you show them a bit of respect it's easier to live. It depends how you behave as to how they see you".

Researcher - What kind of health issues did young people tend to have?

Young person – " 'Erm, it was generally like the main health issues really but more mental really. A lot of mental health stuff. And a lot of self harmers really a lot of

people covered in scars from where they cut themselves. At the end coz I used to get day releases they made the unit where the self harmers went coz they couldn't handle prison and I used to have to go to that unit to work and so I got to see a lot of that as well. They used to have to get the doctor".

Researcher - Did you get any idea whether the people were self harming before they went into the young offender institute or did it develop as a result of them actually being inside?

Young person – *"It was a mixture really. Obviously if you self harm you get the chance to come outside your cell and a lot of them got took down the surgery and down to the hospital wing where they'd give you a cup of tea and some medicine and some of them had a break then from the law. And so a lot of lads do it for that reason. And there was this one lad in particular whose whole body was covered in marks and he used to cut himself really really badly and that was it! They had to get him out of the cell, and he was covered, just covered in blood. And obviously he had a lot of blood on him and cut really deep".*

Researcher - How would you get to see the doctor if you needed to?

Young person – *"I would see them a couple of times. It was mainly that you would do a request to see them. It wasn't too bad you could mainly get in to see them. When I hurt my arm down the gym I got in to see the doctor after three weeks".*

Researcher - Can you remember how long it used to take you to see the dentist?

Young person – *"Yeah, we used to call him the butcher. I mean when you go to the healthcare centre you fill in an application and put your name on it. Then you get to see someone as and when. Then you go down and are with the lads from the other units. That's an experience in itself coz when you've been used to the lads on your unit you get with all the units together, it's really scary. They just call your name out and you see the lads coming out with tissues in their mouth and bleeding. I had a filling, I've got two teeth that were chipped and I didn't have them filled. I was 14 when I did it at a beach in Cornwall. I thought now I'm in I'd get 'em sorted out but I had to come back at another time. My gums bled anyway and he put two fillings in and they fell out the next day. So I still haven't been back to the dentist".*

Researcher - So how long have you been without them now?

Young person – *"I didn't have it done till I was in X Young Offender Institute, but they still aren't done (laughs)".*

Researcher - When you said you went in and they did some kind of assessment, was that some kind of questionnaire they completed?

Young person – *"Well yeah, you come in and the first thing you do is like see an officer and get your uniform and that. They ask you if you've got any marks or*

tattoos and stuff. Then they go through to reception and you see a nurse and they basically ask you some general questions. You see a member of the chaplain and this generally happens over a few days on the induction wing. They tell you what's available to you".

Researcher - So when you went to the doctor did they have your medical record?

Young person – *"They obviously did have a file but I don't know whether that was from my GP or just a file from courts or whatever, I don't know. You're not told about that".*

Researcher - Did you visit GPs before you went to X Young Offender Institute?

Young person – *"Yeah".*

Researcher - What about when you came out, what happened to your healthcare then? Did anyone follow you up?

Young person – *"No, no it was pretty much out of the gates and that was it really. Um, I used to make phone calls back to certain officers coz they helped me quite a lot when I was in there so it was just mainly to let them know how I was doing and just to thank them really. But yeah no-one made contact. You go to probation obviously and I had a probation officer and that was just a weekly visit and that was it really".*

Researcher - So do you have any idea what would happen to people who were unwell when they left?

Young person – *"I'm not sure, I know like the chaplain would talk to you. Because I never dealt with that I had no confirmation anything happened to them. I know the chaplain if you wanted to go to a church would give you details of a church. So maybe, maybe not. I think they were pretty much left to themselves. Once you're outside that's pretty much it unless you came back in again".*

Researcher - One of the difficulties people have told me they can experience in prison is that the dispensary can close before they can get back from work duty to access it. Did you experience anything like that in X?

Young person – *"Um, I know that whenever I worked the nurse would come at feeding time when you're getting your dinner or get you out your cells the lads who needed it and would give out medicine from a trolley. I never had a problem myself. They had like a locked cabinet it was locked with security. I'm not sure if they carried paracetamol".*

Researcher - What about detoxification and illegal drugs? Was there a detoxification programme?

Young person – *“There was a CARAT service. I had a CARAT worker. I wasn’t a massive drug user I used to smoke some weed and before I came in I just started snorting some cocaine. There are programmes and a lot of the lads are addicted to heroin and I’m trying to think how they were getting off the drug. I’m not sure they got methadone; I think they just went cold turkey. I remember there was this one lad, when he came in he was really thin and they used to give him these nutritious drinks to try to get him to put some weight on”.*

Researcher - You said waiting times weren’t too bad. How long would it take you to see someone?

Young person – *“It depends, if it was something like the dentist or the opticians you would wait a long time because it’s not serious. And obviously everyone in there wants to see them. As far as it was with the injury on my arm then that was about two or three weeks. It was still a while. You just well pretty soon you had to wait for a slot. It’s really like you fill in form and give it to one of the nurses”.*

Researcher - What would pretty soon mean?

Young person – *“Depending obviously, if it was life threatening you would be seen straight away. I would say, well yeah well it depends on the officers like. That lad he waited all night in pretty much in excruciating pain. ‘Erm you are advised to put your request in and if it is serious you would be seen almost immediately. Yeah well you would go down and see the doctor. You just fill out a form with your name and put in a request. If you don’t put anything else on it and it can take quite a time”.*

Researcher – So if you’re filling out a request form which doesn’t have any information on it about your medical issue, how do they make a judgment about how soon you need to be seen?

Young person – *“Yeah, I guess that’s down to you. You could put more information on or if you speak to the officers on the wing as well”.*

Researcher - What about the whole privacy issue. There might be things you would rather the prison staff didn’t know? How does it work in terms of privacy, how private is your consultation?

Young person – *“Obviously the whole wing will know when you get called up that it’s time for your STD test or whatever. You just know pretty much from which direction they turn in healthcare who they are seeing and what’s wrong with them. You know dentist on the right. So you pretty much know. Yes it is reasonably private in terms of the staff. Down there the nurse knows and if there’s an issue with it then the officers know. That’s the thing if you get scabies, scabies is quite high, it’s rife in prison and you’re in a complete mess. You’re so fearful you might get it, it’s horrible you really don’t want it. But... ‘erm the lads in the cells who look after people they know who’s got it. Basically you go down, they used to paint you*

in this stuff so basically everybody knew you had scabies. Now it's like a lotion they give and they'll go into your cell even though everyone still knows you've got scabies because the cleaners have to go in our cell and then get rid of all the sheets and that gets tied up and burnt. So everybody on the wing will know by that night who in the cells has got scabies. So it will get around, generally any news in prison will get from one end to the other without lads ever seeing each others in the day. It can get round in a couple of hours".

Researcher - How do they do it? how do they get this information around?

Young person – "I mean you've got like em lads that go round doing the washing and doing collecting towels and what have you, and they know people and talk and that's how stuff gets taken along. Word goes down to the kitchen then back from the kitchen so everybody knows".

Researcher - Do the lads support each other? If somebody was sick would they get support from another prisoner?

Young person – "Um I suppose, I mean you've got a lot of people in there are friends. They know each other from outside as well. I mean like say this is a story I can think of. He wasn't ill but the guy's dad had died. He told me his mum had died before when he was previously in prison so like he was a bit distraught. They organised a viewing and said if he wanted to go to the funeral they would arrange it. And the officers were really good about it as well. He was actually offered if he wanted to go to the funeral, but he said no".

Researcher - Is there any experience you've got where some conditions might get more support than others? Does the kind of condition you have make any difference to the way you're treated by other prisoners?

Young person – "Oh yes the lads who were harming they really get the mickey taken of them generally, and by officers as well. Just sort of taunting and stuff. Generally there's not much sympathy with cutters. There was this one lad who always used to threaten to kill himself; he never actually did it and, ah, he was in his cell and the officer came. He said he was going to hang himself and the officer said 'Oh well I'll come back in ten minutes then.' It happens a lot. They say 'ah well, go back to your cell and cut yourself.' It's like anything though I've always been all right with the officers; firstly I've never caused any trouble. They can be like it with some of them, but there's other lads who wouldn't let them do it to them. They were like my meal ticket as well, I'm not stupid am I".

Researcher - What about lads who didn't have your level of intelligence, lads who may have difficulty understanding things, how did they cope with it?

Young person – "Pretty much they just see those lads a bad guy the whole thing in prison is like that with officers being nasty to lads who just be cocky or disruptive. It's not just, well if they don't realise then the screws would just be abusing, just

shouting. One lad, I can't remember how that situation happened but he'd literally just been let out for dinner then he was being all twisted up with the locks on and whatever. They would do that to you you'd get all twisted up and taken down to the block. But you don't have to be unintelligent, it's so frustrating in there sometimes you can just blow your top. Then after you've got to act towards them in a friendly way obviously just to get around them and stop you being taken down to the block".

Researcher - Would they recognise if anyone had learning difficulties or was feeling distressed and needed some support?

Young person – "Well what it's like with lads like that I'm not sure. If they had personal issues and the like. A lot of things were done privately in that respect. I had like a fight with this lad and in the fight he was like threatening to fight me in the showers 'you are dead' and next thing I know an officer came up to my door and put a note under saying 'are you having problems with this guy?' And so it was done secretly, and so I was like yeah so I told them and the next thing I know he had been a menace on the other unit, so he was moved off the unit. So there is things that go on like that and so I'm not quite sure what happened to other lads. I was known to have a problem and I don't know with the other lads if it was known".

Researcher - Do you think there's anything that could be done to improve how healthcare operates within Young Offender Institutes?

Young person – "I think they need more staff. In X there were a lot of units and they only had a minimal number of staff and because you have all those different units it would have helped to have facilities on each wing. But the lads who really do need help erm... to be fair to them I think they did pretty good".

Researcher - What about when you came out, could anything be improved about your transition?

Young person – "Basically it is pretty much like you'll have a meeting with an officer and you sign papers for your fire arms ban. Everyone get a firearms ban. Once you've been inside you're not allowed to use guns or sparklers (laughter) yeah sparklers right. They're basically classed as a firearm and I've got a five year fire arms ban and say you've got a really bad rapport with a police officer and he really really hates you and he saw you with a sparkler he could arrest you and take you back (laughter). Yes, yes that's a good 'un. So you sign and do that business then you go down to reception and they chuck you out the door. That was my experience though I've never been that person who has had massive issues and gone through what they've gone through but I had absolutely no follow up whatsoever. I was never made aware of what things there were and where, so I'm guessing the same thing happens to all the lads. It was really bad for these foreign lads. They didn't speak a word of English".

Researcher - How did people communicate with them then?

Young person – *“A lot of lads are just pretty much mute. There’s no-one to talk to them and they can’t speak English, but they’ll have other lads in there. This lad had an offender in his cells and he seemed to be the same race and they were together for two years”.*

Researcher - Can I ask you about the regulations in prison, and whether the regulations ever get in the way of healthcare? What would you be first a patient or prisoner? Which takes precedence healthcare or the prison regime if you are sick?

Young person – *“Prisoner! Yeah, yeah most definitely”.*

Researcher - Why?

Young person – *“Because you are a prisoner most definitely. That lad who was left in his cell till the morning, he was ill but he was a prisoner. In a way the whole thing is, you know you get patted down and searched when you go through every door and when I went outside it was probably the most humiliating experience of my life. They took me out dressed in my prison uniform handcuffed to an officer either side of me with little kids looking at me with wide eyes and little old ladies and gents would be looking at you like what you in for? What you done? It’s embarrassing having to take your trousers off for a doctor but imagine with an officer there. I was chained then when they scanned me they put me on this long chain it was like a long metal handcuff chain between me and the officer. Coz obviously you have to be handcuffed at all times, even in the scan it was there. It was long so obviously the doctor could still get to you”.*

Researcher - Have you experienced any kind of prejudice or discrimination when accessing healthcare as a prisoner?

Young person – *“No not really to be honest. The nurses, they were nice they used to chat. The doctor was rude. One doctor was all right. Yeah ‘erm no, there was no discrimination”.*

This interview was taped by the researcher, with the prior agreement of the participant, for the purpose of transcription. The tape will be destroyed at the end of this study.

Appendix K

Head of Healthcare Interview

The following is a transcript of a meeting with the head of healthcare in a men's local prison which had made significant investment in the prison health department. A small team of dedicated staff had made major improvements to patient care and were currently overseeing the building of new purpose built patient facilities within the prison grounds. The head of Healthcare welcomed this study and the opportunity to share her department's work and gave the researcher a tour around the current facility.

Men's Local Prison June 08

"Complaints here are mainly about drugs/pain relief. IMB is really good. We also have really good commissioners who will say no if necessary. They listen and work together with healthcare staff. We also have a really good relationship with the Prison Governors. Two staff are red-listed. Prison awareness training is provided which is useful. There is a need for mental health accommodation in hospital. Transfer times out under section are really bad. 'You've got your health promotions haven't you – never get off the phones – T [previous head of healthcare] got us these facilities!'

We had 11 rooms only with one nurse – old Victorian building. Healthcare officer post was taken away. 11 patients here are high risk one found with a ligature round his neck – one put his arms through the door on fire when she came on duty. PCT plans had enhanced care rather than type three. We needed to make massive change and had stand-up fights. T had the plans for the infrastructure. Our statistics for September were 25 in and three out. We have an observation area, drugs, long-term medical conditions would have traditionally been full of self harm. The PCT staff have looked at it from a Healthcare point of view. From a psychological point of view, self harm triggers self harm in others. People want the care. RMN (Registered Mental Health Nurse) is assessment really quick here, don't need to self-harm any more. Joint care plans in place and RMNs pop over to see them. It's run like a doctor's surgery – although they come along on bulk!

The chief executive of the PCT visited last week, we have MPQL- marking quality of prison life. Independent data.

There is a wide range of cultures within the prison and different cultures for the prison and healthcare staff. People view healthcare staff within the team. The new Governor is really into dignity and respect. Using prisoner's name and title is really important here. IDTs have – integrated drug treatment programme – methadone.

The PCT Board is now aware because of the success of the work and coming to visit. Prison won star award. Won for outstanding treatment and improving

healthcare. V – is a disability specialist here. People can't come in and continue to use their meds. Massive amounts of screening. Healthcare has got a place in induction now.

Proactive now with healthcare staff going over to say this is what we can do to you rather than assuming when you come in have you had to attend. System 1 health screen this and that. Prisoners get paid to attend induction. System 1 health screen 15 questions from 44 people through the gates in remand. Within four days they are down for in-depth examination. Lots of people aren't registered with a GP. We can fax GPs, depends who it is for the quality of the response. Have to take their word for it initially (the prisoners). Our GP fell off his bike but still came in with two breaks. We have a 4,500 turnover in a year – average length of stay is a month. Our operating capacity is going up to 1,100 and we're becoming a community prison. Emphasis is on remand if someone on a sentence only had two days to go but will have to be transferred out. Need to weigh up what's best for prisoner. Lifers now saying to get parole you need to have done a certain amount of courses which you can't access. Titans would have everything with specific areas for different care. Remand – PCTs would lose money. Threat to healthcare if Cat B status is lost. Nurse saved the life of X patient found with rope around his neck. Everyone is now wearing an NHS uniform with RGN or RMN and different colour for grade. Changed because of arms length provision. Sexual health and GU is necessary in prison. Nurses provide condoms. Out of the gate – new build collect people as they come through the doors. I've been here 18 months but really feel I've made a difference. One colleague came back from retirement to see the new build project through.

Get on our 95 RMN referral every month. When people come in and go to court – 'barking mad' they get sent to prison to get them out of the beds to get them off the streets. Barking mad, we don't have the power to treat them.

There is a need to recognise healthcare as NHS, if patient refused meds to enforce it! Desperately needed at least 50% of people could be made well. If I was an NHS nurse in acute I can treat, it should be the same here. Kept somebody here seven months because he was rocking mad for two years in the system. People being fed stuff which only masks symptoms - like Diazapan. It's politically driven to get you off the streets. Nurses in prisons have the same skills, qualifications and better experience – makes sense if they can.

Separate mental health facilities are required. One guy was covered in faeces for months – eventually medicated against his will. We are setting up a Healthcare Forum. Healthcare questionnaires had very rude comments traditionally.

Appendix L

Acting Head of Healthcare Interview

The following interview took place in a women's prison at the invitation of the acting head of healthcare.

"This is an old building which isn't fit for purpose. We would like to provide nurse triage here but there's no space to put it. We have an in-reach drug treatment service, sexual health, mash team, Hep C specialist, in-reach mental health, psychologist, family support worker, smoking cessation, volunteering and a first night centre. People have an initial screening then a second assessment. We have high staff sickness because of the nature of where they're working, the stress and that. We also have drug and alcohol screening.

Following a death in custody we aim to have one nurse and one healthcare assistant distributing medication. We give out over 600-1,000 meds – very high and very high self-harm a year at 2,000 incidents.

We don't have an inpatient service. There are significantly higher literacy issues here and mental health and learning disabilities. We've put a new tender in to involve the voluntary sector and provide full time occupational therapy. We also run an immunisation service and need proper records. The mother and baby unit here is run by a private organisation. We have a female doctor one day a week, dental service two days a week. We've put in a tender for a full time service and for a podiatrist one day a month. A lot of people here should really be in a nursing home. We had to put one sick person in the mother and baby unit because we didn't have the facilities to care here. We have two or three code reds, bullying for medication. We're looking at review from a need rather than a demand and need more GPs.

It's really hard to deal with some of the challenging behaviours and we can get a run of incidents.

We're near the bottom of the shoe as far as the prison staff are concerned. They stand around and read papers while we get attacked. We've been trying to do some work with them around swapping roles and developed a communications plan. We're trying to win hearts and minds but it's about getting systems and processes in place. We're going to run an event.

The first night when they come in here is key. When they arrive a really robust assessment is vital in the first 24 hours. The women here may well need case conferences and planning and if we can do that it's much better and we can identify the resources required and a care plan".

When asked by the researcher whether people were viewed in healthcare as patients or prisoners commented *"they are patients, they are patients. People who*

have worked here a long time don't look like nurses, and the attitude isn't that. The nursing culture is caring. People should wear their uniforms, hand hygiene, no jewellery or nail varnish. They need a hierarchy and process. Someone needs the vision and a transition plan to take us away from the staff issues.

The local PCT thought our tender was essential. They have a non-executive director champion and have realised that prison health will impact its targets.

I'm passionate about equality; my training was about inequality in healthcare and I absolutely support the new tender but I know the Primary Care Trust's infrastructure is really stretched, it's delayed things a year already.

Lots of estate problems here – tender needs to be phased, the vision might have been for a new build. We need strategies for services.

The culture can be very, very abusive to the staff. We're setting expectations within our culture. Patients don't have those boundaries on the outside so we set them out in a simple letter. Need to protect nurses and show respect, a united front with the prison staff would be a help. They think they can access things a bit better inside but they don't. Need receptionist for protection from abuse. Culture doesn't change overnight.

We wanted to set up a prescription to exercise, simple health target messages. Need to get gym and counselling out to the women and away from you don't always need to see a woman. A lot have gone through sexual abuse, loss of children, mental health, self harm and substance misuse, prostitution and abuse.

The ethnic mix here is Asian, illegal immigrants. I'm not sure if their health needs differ but the way they approach healthcare is different because of their level of understanding and beliefs.

People don't access healthcare outside because their lifestyle is too chaotic and something else always comes up. It's a mafia type culture on the outside, fear of authority. They don't have the money to get to the doctors, forget appointments, have poor literacy skills – don't read or write. Fear of doctors is very much a family culture, fear of what they're going to be told they've got, they often sleep in the day if they're night workers, fear of loss of children, person coming might be nosey and many have an inability to remember. It's easier to deal with the Asian women in prison because their husband isn't sitting there.

We have some very dangerous women in here.

We need to improve the appointments system here and patients can drop comments on a piece of paper into a box. We're starting to think about new ways to treat currently we can't give more than three days of tablets.

A lot of what we're expected by prison staff to deliver in here is what you would call social care on the outside. I think the prison performs that function. We have a bunk bed issue as they don't have cot sides, people get injured falling out of bed.

We need a prison hoist but the prison refuses to provide one for the prisoner saying healthcare should provide it. The prison won't provide wheelchairs either and want healthcare to provide those also – so prisoners are isolated and can't get around the prison. They even expect us to provide plaster for small cuts – healthcare wouldn't provide things like that in the external community would they? You would only go to the doctors if you had a significant cut.

We have a very sick women in here who needs social care. Assistance with basic living tasks is required. One woman set herself on fire because she had to wait 15 minutes. She went into the care unit. We need a community care assistant to do a round, we need a resource to draw down when needed – where is social services? They should be in here doing assessments.

We need discharge planning meetings- finding out what's needed for the first time post release leads to many people coming back”.

Appendix M

Carer Interview

The following interview was arranged by the Prison Governor who approached the researcher having read her article in the Health Service Journal.

The researcher met the carer in his cell which was situated in the vulnerable person's wing of the prison. The participant made a cup of tea for the researcher and explained that this was his first experience of imprisonment. He had developed a caring relationship with the elderly prisoner in the cell next door – referred to as H in this interview. The Governor had granted half-a-day paid absence from work to enable the participant to take part in this study.

The participant said, *"I help H with reading and writing; he doesn't want to talk to uniforms. The care is voluntary. I think a lot of people would be interested in caring in prisons. When you first come in people help you. Some cope better than others. Things go through your head. The psychologists train us here for other things like the Listener scheme. We support people who are suicidal, get their meds, help them up the stairs."*

Researcher – How do you know if H needs assistance?

Participant – *H and me have a system – if he needs me he bangs on the wall.*

The researcher commented that if the participant's and H's case the caring relationship had arisen because he recognised a need to provide this support and this was something she had found in other prisons too. It was her understanding that this prison was interested in establishing a formal carer scheme in which carers would be paid for the assistance provided. The researcher asked the participant what he thought of this.

Participant - *"A carer scheme would work here, people would be interested and it could be used on the outside. It's important to get the suitable people and when you get out you could take out a qualification you can use elsewhere and get work in places like youth centres."*

It's hard because sometimes people you care for get ill, released and die. When you care sometimes others take over but it's a bit like a nursing home in some places. I didn't realise how much caring was going on inside.

Staff can't help – two nurses can't be everywhere. Carers have got to be the right ones but there's lads in here that would do it. The buddy's work here now. The phones are a godsend. We can get straight through to the psychologists, Samaritans, bullying hotline in every cell. Free - safe custody. There's a visitor family line which people can use if they have concerns about a visit it's answered

twice a day – it's like a pay as you go. The old system of a phone on the landing used to cause fights.

We've got the Iceburg Programme at X it's very effective for vulnerable people. Grown men won't ask for support – people find their own way to cope.

People who are already disabled on the outside – the majority already have carers. Staff won't do a cup of tea. When people have to go to hospital they are back in here the following day needing more assistance like fetching their meals etc. Friends will go and take letters and make a cup of tea. If you're up all night the psychologists will give you the following day off. A wing-based system would work better. Carer/cared for would have freedom of movement”.

Appendix N

Discussion Group

“Getting a prison escort to hospital is a problem here, it took four days to get one when I had an arm infection. I was chained the whole time”.

“Prison rules get in the way of payments for prisoners. Pay prisoners get can vary considerably around the estate. Disabled prisoners struggle to get any pay”.

“How people speak to older or vulnerable prisoners is really important. They are likely to be frail, ill, particularly first timers. Things need explaining really carefully”.

“Many of the facilities here are upstairs and many of the guys can’t manage to get up there. It’s important to think about the needs of young people as well as frail older people”.

“Training to understand the behaviour of prisoners with mental illness is really important. A florid patient isn’t committing any offence against discipline it may be the only way he knows how to speak. They’re considering setting up a peer mentor scheme here”.

“The doctor here has to try to support 200 mentally ill prisoners. I’ve become really sick here and have lost 90% of the sight in one eye. Sorting out the problems with escorts needs to be a real priority here”.

“Medication keeps getting delayed – patients go mad and get really aggressive”.

“We’ve got up to 50 prisoners on the vulnerable prisoner unit at any time here. They can get bullied. People perceive it as an easy life and get transferred in. Trying to get outside again is really difficult. People are separated on the unit and don’t mix with anyone else. They need to be able to get outside in the fresh air but there’s nowhere for them to sit down so some have to stay inside all the time”.

“People get beaten up and their drugs get taken. One old man, struggling down stairs with his tray got tripped up by one of the lads deliberately. The bullying goes on all the time”.

“Some of the older prisoners here are so desperate for money they sell their medication to buy basic necessities”.

“I had major heart surgery and couldn’t work for seven to eight months. I don’t have any savings and had to survive all that time on £2.50 a week”.

Appendix O

InsideTime Article

October 2006

Has the Transfer of Prison Healthcare to NHS Responsibility, Made a Difference to Your Experience of Health Services in Prison?

'Our health is very important to us, and traditionally patients in prison have experienced wide ranging differences between the healthcare provided across the service. In 1999 the Department of Health and the Home Office commissioned the report *Improving Prison Healthcare* which called for a need for better provision and a much better working relationship between the Prison Service and the Health Service.

From 1 April 2003 responsibility for the purchase of prison health services transferred to the NHS through Primary Care Trusts (PCT's) which made this mainstream activity within the NHS.

As a result, when healthcare is commissioned or provided by the NHS, the NHS (Complaints) Regulations 2004 S/1768 must now be met. Regulation 9 3.32 states that 'Where a person wishes to make a complaint under these regulations, he may make the complaint to the complaints manager or any other member of the NHS body which is the subject of the complaint...These arrangements should ensure complaints are dealt with quickly and effectively. These arrangements should ensure that complainants are made and of the role of advocacy services, such as the Independent Complaints Advocacy Services (ICAS), and how they may be contacted.

I am currently undertaking a research study to look at whether the transfer of prison healthcare has made a difference to the way you experience the health services provided in prison, and would be grateful if you would write and let me know about your experience. My study is under the direction of Professor Tony Butterworth at The Centre for Clinical and Academic Workforce Innovation (CCAWI), Lincoln University.

I would be particularly keen to hear whether healthcare has changed in any way since the transfer? What is your opinion of the healthcare provided in prison? Are there any issues you face in trying to access healthcare in prison? Has being in prison affected your health in any way? Do you have any suggestions for ways in which prison healthcare could be changed? Does the category of prison you are in raise any particular issues for the way healthcare is delivered?

Anything else you would like to tell me about prison health provision would be very welcome. As with my previous work, any comments you make included in the report will not be attributed to you in any way, to ensure your identity is protected. Letters will be destroyed at the end of the study. When I produce the report, hopefully September 08, I will write to InsideTime again to let everyone know it has been published and what the findings of the study were.

I am also hoping to visit a number of establishments to discuss healthcare with patients. I would be grateful if you could advise me whether there is a prisoner health discussion group or similar body in your establishment, and who I should speak to about requesting permission to visit.

Thank you for giving this important issue your attention, and I hope you will write to me at:

J. D. Tabreham
Unit 2.1 Clarendon Park
Clumber Avenue
Nottingham
NG5 1AH

Appendix P

Node Screen Shots

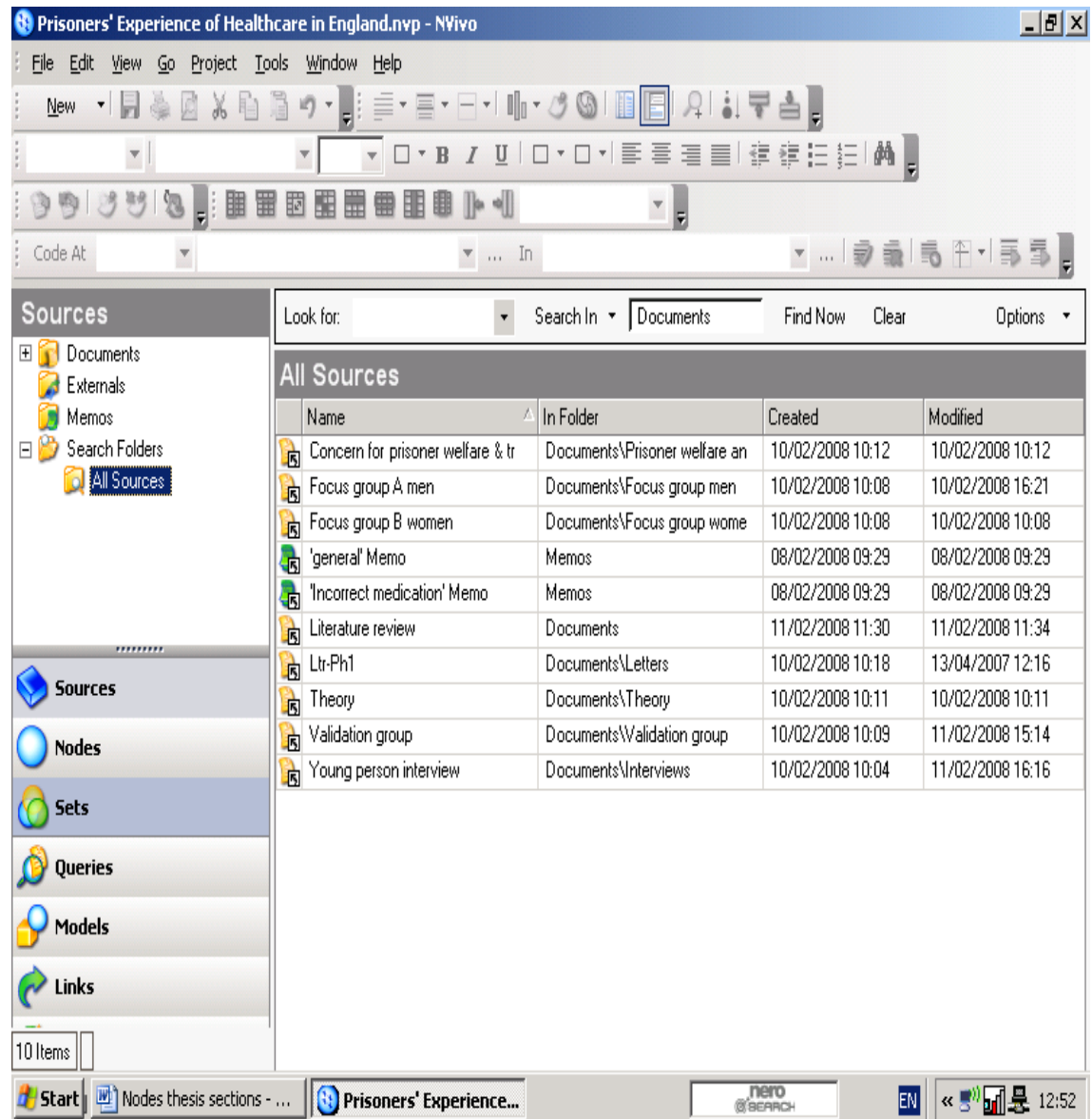
a. Screen shot showing cases

The screenshot displays the NVivo software interface for a project titled "Prisoners' Experience of Healthcare in England.nvp". The left sidebar shows a tree view of nodes, with "Cases" selected. The main window displays a table of cases with the following data:

Name	Sources	References	Created	Modified
Concern for prisoner welf	1	1	13/02/2008 10:01	13/02/2008 10:01
Focus group A men	1	1	13/02/2008 09:54	13/02/2008 09:54
Focus group B women	1	1	13/02/2008 09:57	13/02/2008 09:57
Ltr-Ph1	1	1	13/02/2008 10:00	13/02/2008 10:00
Theory	1	1	13/02/2008 10:02	13/02/2008 10:02
Validation group	1	1	13/02/2008 10:02	13/02/2008 10:02
Young person interview	1	1	13/02/2008 09:58	13/02/2008 09:58

The bottom of the screen shows the Windows taskbar with the Start button, the application name "Prisoners' Experience...", and the system clock showing 12:55.

b. Screen shot showing coded document sections



- c. Screen shot showing example of node context and issues from N7 database

The screenshot displays the NVivo interface for the project 'Prisoners' Experience of Healthcare in England.nvp'. The 'Nodes' pane on the left shows a hierarchical structure with 'All Nodes' selected. The main pane shows a table of all nodes, including their names, parent folders, and creation/modification dates. A tooltip is visible over the 'Modified' date of the second row.

Name	In Folder	Created	Modified
Access to prisoners	Tree Nodes	12/02/2008 08:43	12/02/2008 08:43
Access to prisoners\Research p	Tree Nodes	12/02/2008 08:44	12/02/2008 08:44
Access to prisoners\Research p	Tree Nodes	12/02/2008 08:44	12/02/2008 08:44
Access to specialists	Tree Nodes	02/03/2007 15:21	23/03/2007 11:39
Access to specialists\Access to	Tree Nodes	02/03/2007 15:54	11/02/2008 15:14
Access to specialists\daily canc	Tree Nodes	06/06/2007 19:30	10/02/2008 10:29
Access to specialists\Long waiti	Tree Nodes	02/03/2007 15:54	10/02/2008 10:29
Access to specialists\Refusal of	Tree Nodes	02/03/2007 15:55	10/02/2008 17:23
Access to specialists\Refusal to	Tree Nodes	02/03/2007 15:53	11/02/2008 15:14
Care post-release	Tree Nodes	10/02/2008 11:47	11/02/2008 16:16
Carers in prison	Tree Nodes	10/02/2008 12:07	11/02/2008 15:56
Case Data	Tree Nodes	13/04/2007 12:32	13/04/2007 13:23
Case Data\Category	Tree Nodes	13/04/2007 12:32	13/04/2007 12:32
Case Data\Category\Cat B Men	Tree Nodes	13/04/2007 12:42	10/02/2008 17:59
Case Data\Category\Cat B Rest	Tree Nodes	13/04/2007 12:43	10/02/2008 10:29
Case Data\Category\Cat B Wo	Tree Nodes	13/04/2007 12:42	13/04/2007 12:43
Case Data\Category\Closed Y	Tree Nodes	13/04/2007 14:25	11/02/2008 16:16
Case Data\Category\High Secu	Tree Nodes	13/04/2007 12:40	10/02/2008 10:29

- d. The following table is an example of a node and the sub-issues raised within a theme.

Prisoners' Experience of Healthcare in England.nvp - NVivo

File Edit View Go Project Links Code Tools Window Help

New [Icons]

[Icons]

Code At [Dropdown] ... In [Dropdown] ... [Icons]

Nodes

- Free Nodes
- Tree Nodes
- Cases
- Relationships
- Matrices
- Search Folders
- All Nodes

Sources

Nodes

Sets

Queries

Models

Links

260 Items

Look for: [Dropdown] Search In: Tree Nodes Find Now Clear Options

Tree Nodes

Name	Sources	References	Created	Modified
Access to prisoners	0	0	12/02/2008 08:4	12/02/2008 08:4
Research permission denied	2	2	12/02/2008 08:4	12/02/2008 08:4
Research permission welcomed	2	2	12/02/2008 08:4	12/02/2008 08:4
Access to specialists	0	0	02/03/2007 15:2	23/03/2007 11:3
Access to external appointments	4	9	02/03/2007 15:5	11/02/2008 15:1
daily cancer treatment denied	1	1	06/06/2007 19:3	10/02/2008 10:2
Long waiting lists for external ap	1	1	02/03/2007 15:5	10/02/2008 10:2
Refusal of treatment by specialist	2	3	02/03/2007 15:5	10/02/2008 17:2
Refusal to facilitate hospital treat	4	6	02/03/2007 15:5	11/02/2008 15:1
Care post-release	2	6	10/02/2008 11:4	11/02/2008 16:1
Carers in prison	5	10	10/02/2008 12:0	11/02/2008 15:5
Case Data	0	0	13/04/2007 12:3	13/04/2007 13:2
Category	0	0	13/04/2007 12:3	13/04/2007 12:3
Cat B Men	2	8	13/04/2007 12:4	10/02/2008 17:5
Cat B Restricted	1	1	13/04/2007 12:4	10/02/2008 10:2
Cat B Women	0	0	13/04/2007 12:4	13/04/2007 12:4

Start Prisoners' Experience... Microsoft Word nero @SEARCH EN 13:03

Example of node tables from initial phase of project showing sub-issues

Node 1 Variation in Healthcare Provision

Cluster (Node) 1	Sub-issues
Variation in healthcare provision	Variation in standard of care Variation of provision in different prisons

Node 2 Medication

Cluster (Node) 2	Sub-issues
Medication	Alteration of medication prescribed by previous clinician Damage to health caused by incorrect medication Delay in receiving prescribed drugs Drug testing preventing medication being prescribed Incorrect medication Insufficient medication Medication being messed with Medication denied Medication incorrect Medication not treating prisoner complaint Medication thrown away Pain management - medication insufficient for needs Previously prescribed medication denied in prison Refusal to allow painkilling medication Staff ignoring medical advice about patients' medical needs Staff stopping medication Vitamin drink denied Waiting times to receive prescribed spectacles

Node 3 Healthcare Facilities

Cluster (Node) 3	Sub-issues
Healthcare facilities	Improved facilities Mental health facilities required

	No access to palliative care No facilities for disabled prisoners No self-help No well-woman clinic Poor diet Unhygienic healthcare facilities
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Node 4 External Support

Cluster (Node) 4	Sub-issues
External support	In-reach unavailable Lack of appropriate adult Lack of key worker Poor solicitor Social worker unavailable

Node 5 Dispensary Opening Times

Cluster (Node) 5	Sub-issues
Dispensary opening times	Inflexibility of medication dispensary

Node 6 Illegal Drugs

Cluster (Node) 6	Sub-issues
Illegal drugs	Cold turkey leading to suicide Danger to ability to remain clean Detoxification cold turkey on entering prison Detoxification had reverse effect on drug use Detoxification interfered with existing medication Positive test, refusal to otherwise treat Threat from other prisoners

Node 7 Medical Records, Assessment

Cluster (Node) 7	Sub-issues
Medical records - assessment	Hospital not forwarding on medical records Medical information not requested No medical records system

Node 8 Healthcare Staff

Cluster (Node) 8	Sub-issues
Healthcare Staff	Doctor turnover

	Healthcare personnel forming united front against prisoners Healthcare staff unable to speak English Human rights violated Inexperienced agency staff used for vulnerable prisoners Inexperienced healthcare staff (agency) Lack of knowledge Lack of knowledge and understanding of complex medical condition Language barrier (foreign national prisoner) Nurses undermining doctor's decision Patient subject to racial discrimination by healthcare staff Poor quality of available medical staff Poor service (availability of healthcare staff) Poor staff attitude Prejudice against prisoner Racism Rude, aggressive staff Staff stopping medication Staff threats Uncaring attitude of prison medical staff
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Node 9 Privacy

Cluster (Node) 9	Sub-issues
Privacy	Lack of facilities for private consultation Letters read

Node 10 Treatment

Cluster (Node) 10	Sub-issues
Treatment	Delay in specialist equipment provision Denied medical treatment Different treatment by healthcare staff within prison service Discriminatory treatment Fear health is deteriorating Governor improved treatment Insufficient medical investigation Involved media to access care Involved politician to access medical treatment Involved solicitor to access medical treatment Lack of information about condition Lack of mental health facilities Mental health deteriorating

	No assessment done No rehabilitation for mentally ill No specialist treatment Placed in wrong establishment Poor service (treatment and care) Results not given Specialist treatment denied (mental health unit) Specific treatment not available in prison Treatment based on the risk you are deemed to pose Treatment decisions by other than doctor Treatment worse inside Wait worsened condition Wrong treatment Wrong treatment prescribed against specialist report
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Node 11 Access to Specialists

Cluster (Node) 11	Sub-issues
Access to specialists	Access to external appointments (specialists) Cancellation of secondary care appointments Daily cancer treatment denied Lack of availability of physiotherapists Long waiting lists for external appointments Refusal of treatment by specialist staff Refusal to facilitate hospital treatment

Node 12 Waiting Times

Cluster (Node) 12	Sub-issues
Waiting times	Chiropodist Delay in external results Dentist Difficulty accessing healthcare Doctor Optician Waiting times specialist

Node 13 Complaints

Cluster (Node) 13	Sub-issues
Complaints	Complaint information not provided Complaints not taken seriously Fear complaint may be intercepted

	<p>Fear of accusations by medical staff</p> <p>Fear of punishment for reporting medical complaints</p> <p>Feeling coerced to drop medical complaints</p> <p>Had to log complaint with person it is about</p> <p>High level complaints about the same clinician</p> <p>Long turn around for resolution of complaints</p> <p>Malicious staff reaction to prisoner complaints</p> <p>Medical complaint ignored</p> <p>Medical information not provided for complainant</p> <p>Non NHS provision exempt</p> <p>Photocopier needed to assist complainants</p> <p>Solicitor unable to assist</p> <p>Staff lying</p>
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Node 14 Prison Regulations

Cluster (Node) 14	Sub-issues
Prison regulations	<p>Prison regulations put before healthcare issues</p> <p>Unable to access medication</p> <p>Poor treatment led to increase sentence length</p> <p>Unable to access specialists</p>